

# The MODERN HOSPITAL

Vol. XXXIV

February, 1930

No. 2



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## *In This Issue*

Believing that the backbone of the hospital is its medical staff, Doctor Faxon, in the opening article this month, analyzes hospital staffs in general and especially the staff of the teaching hospital.

Doctor Goldwater discusses the amount of bed space necessary in a maternity hospital, and suggests that 80 feet of floor space per bed will fully meet all the basic needs. His article appears on page 57.

How the Methodist Hospital, Indianapolis, reduced its fire hazards by erecting for the storage of x-ray films a vault that incorporates the best in technical and safety features is described by Doctor Echternacht on page 59.

That hospitals have a moral as well as a legal obligation to their patients in preventing accidents within the building and how such accidents may be

prevented is the theme of an article on page 65 by Doctor Hinenburg.

Miss Raymond, on page 73, tells how a hospital successfully financed a nurses' home by planning a building with shops on the ground floor, the rental of which paid the interest on the investment.

A simple method of recording the relationship between a hospital's budget and its actual income is described by Doctor Buck and Doctor Jordan on page 77.

It is generally agreed that music acts as a tonic in helping to restore the ill to health, and Miss Ilse, on page 81, contemplates the possible practical applicability of music to hospitals in the future.

Miss Ferguson, on page 87, explains how medical social workers receive their best training in teaching hospitals.

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# THE MODERN HOSPITAL

*A Monthly Journal Devoted to the Building, Equipment, Administration and Maintenance of Hospitals and Sanatoriums.*

Vol. XXXIV

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No. 2

## A Hospital Director's Analysis of Hospitals

By NATHANIEL W. FAXON, M.D.

Director, Strong Memorial Hospital, Rochester, N. Y.

**R**ECOGNITION of the importance of the art and science of medicine to the individual and to the community has been shown by a growing public interest, by increasing expenditures for public health, by improved medical school teaching and by the phenomenal growth in hospitals. Municipalities, foundations and private philanthropies have all recognized the importance of the hospital to modern medicine and have provided liberally for the building of hospitals throughout the United States.

More or less careful study of conditions has preceded the erection of each institution, sometimes, unfortunately, less rather than more. Most of those studies have been made by people associated with or interested directly in hospitals—doctors, nurses, hospital administrators or hospital trustees. Of late, there has been a growing interest in medical matters on the part of the lay public, and many articles have appeared in magazines about the high cost of medical care and hospital costs in particular. This interest is most desirable even though in many instances the criticism has been extremely caustic. Unfortunately much of this criticism has been based upon premises which, although true in certain instances, have not been representative of average conditions. Most of the articles have dealt with the private hospital. Little attention or consideration has been given to general teaching hospitals or to university hospitals which form an important group, although small in numbers. It is impossible to consider hospitals without con-

sidering doctors, or to consider doctors without considering their particular problems, and especially their code of medical ethics.

The backbone of a hospital is its medical staff. The physical plant may increase or decrease the efficiency of the workers within its walls, but the organization, rules of conduct and coordination of effort of the individuals making up the staff of a hospital determine the true effectiveness of that hospital. Believing that the staff of a hospital is its most important factor, an attempt is made here to consider hospital staffs in general, but especially to consider the organization of the staff and the relation of the general teaching hospital connected with a medical school, to its staff.

### *How Patients Should Be Transferred*

The part of medical ethics that requires the complete transfer of a patient under active care from one doctor to another is founded upon sound medical principles, rather than, as is commonly considered by the public, upon the desire of the doctor to maintain a proprietary control of the patient. Any other procedure might lead to serious complications in the treatment of a patient. If two physicians were engaged at the same time in the separate conduct of a case, the directions and medicines ordered by one might seriously conflict with those ordered by the other and neither would be able to judge intelligently as to the progress of the patient.

Similarly, it is desirable that patients entering a hospital do so upon the recommendation of

their family physician, and the generally accepted policy of the relation between hospitals and physicians practicing medicine in the community is that hospitals shall admit only those patients who are recommended to them by physicians. But while this policy is desirable, there is a growing realization that rigid adherence to it is impossible. It is obvious that it cannot be applied to emergencies, to accidents and to certain critically ill patients who may be brought to the hospital without having been seen by a physician. Moreover, since the patient is completely under the control of the hospital physicians, there is no danger of double treatment. When the patient leaves the hospital, complete information of the conduct of the case can be sent to a physician for the continuation of treatment. A further complication is that patients do not understand why a recommendation from a physician is requested, and resent questioning by the hospital authorities as to their reason for seeking hospital care. Neither is adherence to this principle as necessary when a considerable time has elapsed since the last visit to a doctor or when the patient seeks treatment for a different ailment quite unrelated to previous sicknesses, or when the patient has no regular physician, as for instance, when he has moved from one place to another.

These general principles are applicable to private patients paying professional fees and to patients paying no professional fees. As generally interpreted into concrete workable details, they operate as follows:

#### *Admission Regulations Are Important*

Patients applying for admission to hospital wards or to the out-patient department, where no professional fee is paid, should, whenever possible, be recommended by a physician. In emergencies, in the absence of a relative or of an attending physician or in unusual situations, the patient may be admitted and the doctor, if the patient has one, notified and information requested as to the medical and social aspects of the case. A patient may also be admitted if he can give satisfactory evidence that he is not and has not been under treatment by a private physician and that he cannot afford to pay for examination and treatment by a private physician. Upon leaving the hospital ward, the patient is advised to return to his physician, or, having none, is referred to a physician, or if he is unable to pay for care by a private physician, to the out-patient department.

Patients applying for admission as private patients of the hospital staff, either as office patients or for care in private rooms, should be

recommended by their physicians or should give satisfactory evidence that they are not under treatment by another physician or that they have told their physician that they are going to discontinue his services.

#### *Classifying Hospitals*

Hospitals at present are loosely grouped as charity hospitals, private hospitals operated for profit and incorporated charitable hospitals operated without profit and endowed to varying degrees. Originally charitable hospitals were for the poor only, but the advantages of hospital care that came with anesthesia, asepsis and modern methods of diagnosis and treatment quickly brought about the admission of private patients as well. Of late there has been a growing realization that most hospitals lack provision for the care of patients of moderate means, the middle class, who are neither rich enough to pay for private rooms together with generous professional fees nor poor enough rightfully to accept charitable care, whether hospital or medical. Medical charity means that although a ward patient may pay in full for hospital care, if no professional fee is paid to the doctor then that patient is accepting medical charity. Doctors are always ready to give of their services to those who cannot afford to pay, but patients who can afford to pay for professional services should never be allowed to escape that obligation by entering for ward care. This applies particularly to the middle classes or the patients of moderate means, as they are frequently designated.

To adjust themselves to changing conditions and especially to provide for the care of middle class patients, it seems probable that in the future, hospitals will be divided somewhat more definitely than at present into the following groups:

1. Federal, state and municipal hospitals supported from taxation and admitting only free patients or patients paying small sums.
2. Private hospitals operated for profit, providing accommodations according to the class of patients admitted, and admitting a negligible number of patients paying less than cost, intended for patients paying such hospital costs and professional fees as may be charged.
3. Endowed charitable hospitals operated without profit, admitting ward patients paying hospital charges in part only or none at all, the cost of whose care is paid from endowment funds, ward patients paying only hospital charges without professional fees; patients of moderate means paying in full for private hospital accommodations and a restricted professional



fee; and private patients paying for more elaborate hospital accommodations and professional fees of the same grade as in private hospitals. Some of the part-pay or free ward patients would be eligible for care in municipal hospitals, but would be admitted to the endowed hospital for special reasons. Others would come from towns or cities having no hospital.

The federal, state and municipal hospitals will probably be staffed by full-time salaried physicians.

The staffs of the private hospitals will be loosely organized groups of practicing physicians caring for their private patients.

The endowed charitable hospitals will present varied staff organizations such as (1) a full-time salaried staff; (2) the older type of organization of physicians gratuitously giving a portion of their time taken from private practice for the care of part-pay and free hospital patients; and (3) a group composed of a few full-time salaried physicians and a larger number of part-time unsalaried practicing physicians. It is in these hospitals, many of which will be connected with medical schools, that most of the teaching and by far the greater part of serious scientific investigation will be carried on.

#### *What the Group Clinic Offers*

Specialization in medicine has brought about the development during the last twenty-five years of group clinics, which are essentially private organizations presenting many of the advantages of larger hospitals. In these group clinics, each member is supposed to contribute some particular skill in diagnosis or treatment not possessed by the others. Such groups offer an economic advantage to the patient, as compared to an unorganized group of private physicians in that one fee may be charged to cover the cost of varied and elaborate diagnostic investigations. They offer the advantages of better diagnostic facilities, with laboratories and costly apparatus beyond the reach of the individual physician, together with ease of consultation in obscure cases. They are operated for profit. Many of these group clinics are connected either directly or indirectly with private hospitals.

In contrasting the private physician, the group clinic and the endowed charitable hospital, it will be found that each offers something that the others do not possess.

The private physician offers more intimate association between patient and doctor; the ability and willingness to bring medical care to the house of the patient and an equal or greater ability to treat the less serious conditions.

Group clinics offer better diagnostic facilities for more obscure conditions and more varied and greater skill in the treatment of serious diseases, while at the same time they maintain to some degree the personal association between patient and doctor. The individual members of the group may also visit in the home of their patients.

#### *Endowed Hospital Service Best*

Endowed hospitals and their staffs offer the best that there is in medicine, both for the diagnosis and treatment of disease. They can provide laboratories, diagnostic equipment and facilities for treatment beyond the means of individuals and of most group clinics. They are necessary for the instruction of future doctors and for the advancement of medicine through scientific investigation. But because of their size and their complex organization, they tend strongly to operate impersonally and so to lose in great part the personal touch. This tendency can be overcome by fostering a more personal relationship between patient and physician. An institution does not practice medicine but patients are attracted to hospitals because they have confidence in the physicians upon its staff and because of the facilities at their command. The same principle of one doctor in charge of each individual patient inside of a hospital is as important as it is for the patient outside of a hospital. The ward or division patient should and usually does look upon the intern or resident as his private physician, a physician who can call at will upon his superiors for advice and assistance. The private patient naturally looks upon the physician to whom he pays a professional fee as his private physician.

Physicians having private patients in hospitals should conscientiously visit their patients promptly after their admission and should actively direct the conduct of their cases, calling upon the resident and nursing staff to assist and explaining to the patient the relationship of the members of the resident staff. This sequence, perhaps of slight importance as regards the medical conduct of the case, is nevertheless extremely important in the psychological effect upon the patient. In one instance the patient receives the impression of personal attention and in the other, of an impersonal routine.

Hospital care of patients does move more slowly and so requires a greater expenditure of time by the patient but it is also generally more thorough. It cannot, however, offer house visitation or care.

Perhaps as time goes on, the ethical barriers that were necessary to the older medicine may

disappear and people may choose freely between physician, clinic and hospital, exactly as they chose in the past between physicians. There is not really as much undesirable or unfair competition between private physicians and hospitals as at first appears; each upon consideration is shown to possess both advantages and disadvantages. If such choice is allowed, care must be taken that it is not at the expense of charity. The endowed charitable hospitals must, through appropriate organization and examination, separate patients into their proper groups—free, part-pay, moderate means with professional fee, and private with professional fee, each group according to its means.

#### *How to Give Satisfactory Service to All*

Medical and hospital care is a commodity that cannot be treated, at the present time, in the same way as ordinary merchandise. To place a fixed price upon such care and to adhere rigidly to such price, as may be done for a suit of clothes, on the take-or-leave-it plan, will deprive a sick person of needed medical care, encourage mendacity and pauperism on the part of certain patients, deprive the doctor of a legitimate fee, or produce different grades of medical service. Hospital accommodations may vary, such as private rooms or ward beds, without affecting the quality of medical service, but no one wants inferior medical service. Everyone wants, and it is to the advantage of the community to see that everyone receives, the best medical care possible. The present system of examination and classification of patients according to their economic status is an attempt to provide the best medical care for all classes of persons without the abuse of charity or the loss of self-respect from such abuse. There is undoubtedly room for improvement in the application of this system and above all there is need that it be understood and appreciated by the public.

Perhaps the solution of these difficulties lies in the adoption of some plan of insurance applicable to all classes of society. That such a plan is complicated and subject to many abuses is evident from the experience of European countries, such as Germany, Denmark and England, which have adopted such an insurance plan for wage earners below a certain level of wages, approximately, if interpreted into United States wages, of \$20 a week. One grave defect of this plan is that it cares for only one section of the community, leaving out the large middle class group, to which much consideration is now being given. There are many other difficulties of organization and operation, but insurance against sickness,

meeting hospital and medical charges and providing living expenses when wages cease, promise the most hopeful solution for this complex problem.

The endowed charitable general hospital connected with a medical school is the most complex of all hospital organizations and at the same time the one offering the greatest variety of accommodations to patients, and through teaching and research, the greatest returns to the community that supports it.

The primary function of this kind of a hospital is the care of its patients. The best efforts of its doctors, nurses and employees, the activities of all its various departments, must be directed toward providing the best medical care for the sick and offering the best advice toward prophylactic measures and preventive medicine. It must possess the confidence of the community and must represent to them the opportunity for medical care in which they can trust. It must stand for scientific progress. Investigation and research into the causes of disease and improvement in the methods of diagnosis and means of treatment are essential in order that progress may be made.

In a teaching hospital connected with a medical school, there is the added duty of instructing medical students. This obligation, important as it is, must never be fulfilled to the detriment of the patient. There is no need for the interests of the medical student and the patient to conflict for experience has repeatedly shown that patients invariably receive better medical care in teaching hospitals. Nevertheless, it is advisable to emphasize the importance of the patient's welfare above all other considerations.

#### *The Situation in the Teaching Hospital*

The teaching hospital must operate under certain limitations. Because of the necessity of coordination of teaching, care of patients must be limited to staff members, which means that other physicians sending patients to the hospital must relinquish control. This situation is largely compensated for by the requirement of recommendation for admission and by sending to the recommending physician a complete summary of the patient's record so that the hospital becomes almost a consultation service. The presence of medical students on the wards or divisions often causes patients to fear that they are being experimented upon and gives them the feeling that the quality of their care, because medical students participate in it, although under supervision, is inferior. This fear is utterly unfounded because experience has shown repeatedly that the quality of medical care, when students are present, is



usually higher than in nonteaching hospitals, largely because the staff is stimulated by the presence of a group of intelligent inquiring minds. The use of patients for clinic teaching, through case records and demonstration of the actual case, should, of course, be carried on only with the consent of the patient and under these circumstances can be open to no objection.

#### *Rewarding Hospital Physicians*

Another responsibility of a hospital is to recompense in some manner the physicians upon its staff for the time, energy and skill that they give towards the care of patients unable to pay for such care. Such recompense should be made according to the amount of time demanded of the physician. To those who give only a portion of their time, the opportunity of gaining additional clinical experience by service in the hospital, plus the right to care for private patients in the rooms provided for such patients by the hospital—this right not being granted to physicians not on the staff—is sufficient. To others who give their entire time, a salary is necessary in order that they may be assured of financial support for themselves and families.

These various duties—the care of patients, teaching, research and the reward of the physician—must be coordinated in the hospital staff to the advantage and satisfaction of the patients, the students, the community and the doctor. The most casual study of the situation discloses the multiplicity of interests involved, the varied demands upon the members of the hospital staff and the difficulties of finding time for one or even many individuals to carry out these many assignments. Can any individual adequately care for patients, carry on a teaching schedule calling for the accepted instruction of students in small groups approaching individual instruction, and still retain the necessary interest and find the time to carry on investigation on medical problems? The most famous physicians have successfully accomplished this task and their example should lead us to continue a system that they have shown to be signally satisfactory.

In considering the composition of the staff in a teaching hospital, the initial premise must be taken that all members of the staff are interested in teaching. If they are not, they should not be on the staff of a teaching hospital. Admitting, then, that all members of the staff are teachers, should all be expected to carry on clinical work and research also? Or should they be divided into (1) teacher-investigator-clinicians or (2) teacher-clinicians and teacher-investigators? Although the latter division makes fewer demands

upon the individual and is easier of fulfillment, it is, in my opinion, less desirable in the long run, because it leads ultimately to a one-sided development.

The teacher and investigator who looks upon patients merely as examples of what he is teaching or investigating loses something that is essential to the doctor. Humanitarianism, the kindly spirit of the art of medicine, or whatever it may be called, is something that is not only important to him as a physician but also to the hospital. Only such hospitals endure as administer medical aid with sympathy. A sympathetic attitude of mind towards the patient is essential to the teacher of clinical medicine. To retain this leaven of sympathy, the clinical teacher must care for patients as individuals. He must carry his share of the care of patients in the wards and in the out-patient department. He must have private patients whose ailments he must personally investigate, whose whims he must gratify or control through his knowledge of therapeutics, psychology or the art of medicine. He must be interested in patients as sick persons who look to him not only as a wise physician, trained in the scientific investigation of their ills, armed with the best that modern medicine can supply to relieve their condition, but also as a friend whose sympathy tinctures his ministrations though his mind must rule his heart.

The teacher of clinical medicine, then, should be a clinician, having private and ward patients, a teacher instructing students and, that he may always keep alive the inquiring mind of the scientist, an investigator interested in the discovery of new truths and the solving of medical problems. Each member of the hospital staff should have these essential characteristics, but beyond this their relations to the hospital may vary. They may be full-time workers on salary or part-time workers on no salary or some gradation between.

#### *Chief Must Be Full-Time Physician*

The administration of a teaching service added to clinical, teaching and research duties requires that the chief of service be a full-time physician. As such his entire time is given to his joint duties as chief of service in the hospital and professor of the corresponding department in the medical school, inasmuch as these two positions generally go together. The general ward service is the most important service in a hospital since it serves the greatest number of patients and offers the largest variety of medical conditions for the teaching of students. As such, it should be under the direction of the chief, who should, by carry-

ing a ward service himself, impress upon the staff and the students the importance of general medicine. He should be directly and through his assistants responsible for the care of all patients on his service and for the arrangement and carrying out of the teaching schedule for students and he should by example, through conducting some experimental work, encourage research by all members of his staff. He should direct and oversee the resident staff of his service. In short, his influence should extend throughout his entire service. His salary must be such that he may adequately support himself and his family in comfort.

#### *Receiving Private Patients*

In order that members of the community may enjoy the benefit of the clinical skill of the physicians, in order that the physician himself may gain by the discipline of personally examining and treating patients, and in order that he may by example direct and teach his students by the more intimate knowledge that comes through private patients, it is desirable that all staff members not only have the right to but actually do care for private patients in the hospital.

The professional fees from these patients may be turned into a general teaching fund, they may be reserved as an addition to the departmental budget or they may be paid to the physician himself. Of these three choices, I believe the last is preferable because it provides an incentive to the doctor to please his patients, allows him to control the number and selection of patients, which is difficult if they are impersonally admitted as hospital departmental patients, and because he receives tangible compensation for his efforts. The private patient expects and demands more time from his physician than the ward patient and the institution or the doctor should be compensated by a professional fee for this demand upon the staff member's time. That the full-time physician working under such an agreement will voluntarily limit his private patients to numbers that will not interfere with his clinical work in the wards, his teaching and research, is taken for granted. If he transgresses, he should be asked to resign and to take up private practice. Such an agreement has been found practical and does not interfere with the accepted duties of the full-time staff member. In addition, it helps him to retain an interest in the details of clinical examination, diagnosis and treatment, it permits the selection of such patients as he desires, it increases his salary and it brings about greater contentment and a more normal relation with the community in general.

No one physician may encompass the whole of modern medicine, nor can one physician teach all branches of medicine, so it is necessary that each chief of service have assistants. In medicine and surgery, in addition to assistants in internal medicine and general surgery, the demands of the subdivisions of orthopedics, otorhinolaryngology and urology in surgery and of neurology and psychiatry in medicine, require the appointment of staff physicians in charge of each specialty; while in pediatrics, obstetrics and gynecology, since no subdivisions have been developed, only general assistants are needed. Inasmuch as these assistants are required, as is the chief of service, to perform clinical service to patients, to be responsible for the teaching in their subdivisions and to carry on research, it is advisable that they, too, have full-time appointments.

Although it is desirable that additional part-time physicians assist in the general departments and in the specialties, I believe it is necessary for the benefit of the patients that those in charge of the specialties be on full time and at all times available for the care of patients in their specialties and for consultation in doubtful cases. Dependence upon part-time physicians usually means delay since they are only expected to spend and only can spend a portion of their time in the hospital. Full-time service means a shorter stay in hospital for patients. The salaries of assistants should be proportionately smaller in accordance with their comparative rank, but must be such as to attract and retain competent men. I believe they also should have the privilege of receiving professional fees from a limited number of private patients, for the same reasons previously set forth.

#### *Part-Time Physicians Are Needed*

The members of this full-time staff are responsible for the routine care of patients in the hospital. They must carry the burden of student teaching and the medical world and the general community will look to them to produce some new discovery in science and some improvements in medical practice. But if the hospital with which they are connected is most fully to serve the community in which it is placed, then there must be a connecting link and this connection is best provided by the inclusion in the hospital staff of part-time physicians in active practice in the community.

The part-time physician on the hospital staff should be chosen from those physicians of the community who first of all have an interest in teaching, who have retained their interest in investigation and who wish to improve and increase



their clinical knowledge and skill. To such the hospital can offer full return for the time they give to the care of patients, through the opportunity of laboratories, clinical experience, the encouragement to clarify and formulate their experience and knowledge through teaching and the stimulation that comes from association with a group of men actively engaged in research and teaching. Since the demands upon their time are not such as to interfere seriously with their private practice, and the return they receive in experience and prestige from their association with the hospital is recognized as sufficient compensation, it is generally accepted that they should receive no salary from the hospital. Many medical schools, however, do pay a small salary for teaching, usually on the basis of the number of teaching hours contributed.

#### *Humanizing Hospital Service*

The part-time physician brings to the hospital a sympathetic attitude towards patients and a knowledge and skill in the art of medicine gained through the necessities of private practice, that should be taught insofar as they can be taught or at least demonstrated to the medical student. Medicine is admittedly more scientific than it used to be, more exact, better controlled by precise tests, but there is still need for sympathy, kindness, a knowledge and understanding of human nature, ability to gain the confidence and obedience of the patient, these intangible things that constitute the art of medicine. Physicians in private practice must practice the art of medicine as well as the science of medicine. They also serve to connect the hospital with the people of the community and prevent it from becoming an isolated introspective medical factory. They are the wires that transmit the medical energy produced by the dynamo of hospital activity to the homes and individuals of the community.

So far consideration has been given only to the duties of the staff towards the patient, the student and the community. But since in all bargains each party must give something to the other if both are to be satisfied, it will now be necessary to consider what the hospital and the community must give to the staff physician.

Time is a most important element to the hospital staff. It is an advantage to the physician to be able to concentrate his efforts within one hospital—his patients, his teaching and his research—rather than to have his patients scattered in several hospitals, his teaching perhaps in one of them and his research laboratory in another. It is of advantage to the hospital to have a physician spend his working hours within its walls; his

interests are centered, he is available for immediate call to see patients.

To obtain these advantages, the hospital should provide the necessary facilities for his work, rooms for private patients and ward service for clinical experience and laboratories for research. Rooms for private patients should be so graded in price as to accommodate all classes, from those of moderate means to the wealthy, for it must be remembered that all physicians and especially the younger men occupying the position of assistants will draw the majority of their private patients from people of moderate means. If the conclusion that staff members should care for private patients is sound, the hospital, if it is to provide adequate facilities for its staff, must include a number of moderately priced rooms for private patients of limited means.

Care must be taken especially in a teaching hospital to prevent the encroachment of the private service upon the ward service, which is essentially the teaching service. Although in many instances private patients may be used, with their consent, for teaching, nevertheless such cannot be considered a reliable teaching service and the ratio between private and ward beds should be carefully considered. The number of private rooms should only be such as to provide sufficient beds so that each member of the staff may have enough private patients to keep up his experience in handling such cases, to accommodate the community and to augment the physician's salary. As has been stated, the private patients must not encroach unduly upon the time necessary for the care of ward patients, teaching and investigation.

#### *Full-Time Physicians Need Private Offices*

If the physician is to concentrate his time and efforts within one hospital, it is apparent that not only must rooms and beds be provided for patients needing care within the hospital, but that facilities for the care of ambulatory patients must also be provided. It is necessary for the physician to be able to examine patients before recommending their admission to the hospital and to continue treatment and observation after they leave the hospital. While the exact details of providing offices for this service have not been as clearly worked out as those relating to the patient within the hospital, several plans offer reasonable practicability. The out-patient department already provides this care for patients who would occupy wards within the hospital. For the care of private patients, either individual offices for full-time men must be provided or a suite of offices large enough to meet ordinary demands.

Some such plan which gives to the physician in return for his services to patients, his teaching and investigation, facilities for the conservation of his time, the accommodation of his patients, and a means for increasing his salary through his own efforts, seems only just.

From an administrative standpoint, the ideal staff of an endowed charitable general teaching hospital should consist of full-time physicians on salary, in charge of the general services, assisted by other full-time salaried physicians acting as assistants, both in the general departments and in the specialties, and in addition practicing physicians on part time without salary assisting also in the general departments and specialties. All members of the staff should engage in clinical work, teaching and research, it being understood that the major part of each of these divisions should be borne by the full-time staff.

#### *What Hospital Plant Should Include*

The hospital should provide a sufficient number of private rooms for the care of private patients, other rooms for patients of moderate means and an adequate number of ward beds for the care of patients unable to pay professional fees. Offices and an out-patient department are necessary for the proper care of private and other ambulatory patients and the conservation of the physicians' time. Laboratories should be provided for clinical examinations and research. There should be a suitable and efficient organization to separate patients into proper groups and to prevent the abuse of charity.

The administrative machinery of the hospital should segregate patients according to their economic condition into free, part-pay and pay patients paying no professional fees, and private patients paying professional fees. Only the hospital accommodations provided for these classes of patients should differ; the medical and nursing care should be the same.

Such a staff and such a hospital offer the maximum for the skilled and intensive care of patients, for well balanced and well correlated instruction to students and for scientific investigation. They provide mutual advantages through association to both full-time and part-time physicians and they connect the hospital with the community. The director of the hospital and the chiefs of the various services should work together to coordinate the many individuals composing the hospital staff into a flexible efficient organization, while still allowing personal freedom and initiative, bearing always in mind that all should unite in the task of solving medical problems and in the care of the patients.

## Bellevue Hospital Will Erect Psychiatric Unit

Announcement was made recently of a new \$3,500,000 psychiatric hospital to be erected by Bellevue Hospital, New York, to replace the old psychopathic wards. The new unit, one of the first municipal institutions devoted solely to illnesses of the mind or nerves, is to be built on the block bounded by the East River, First Avenue, Twenty-ninth and Thirtieth Streets, Dr. William Schroeder, Jr., announced.

The hospital, designed in modern Italian Renaissance style, will be thoroughly modern with many new features for treatment of patients. The walls will be of brick, with a granite base and trimmed with limestone and terra cotta. The hospital will accommodate 600 beds and will be ready for occupancy in two years, it is hoped.

Dr. Menas S. Gregory will be in charge of the psychiatric hospital.

Decision to build the new psychiatric unit entirely separate from the general hospital buildings was made to facilitate the work in each, Doctor Schroeder stated.

"Upon completion of the hospital," the doctor announced, "the old psychopathic wards will be discontinued and all mental or nervous cases will be removed from the Bellevue grounds. I feel that this will be to the ultimate advantage not alone of the mental and nervous cases but also to those in Bellevue Hospital receiving medical and surgical treatment.

"A large number of the more important hospitals for mental and nervous cases in this country and abroad were visited and exhaustively studied and observed before plans were completed for this building."

Radical differences between the old psychopathic wards and the new building were pointed out by Doctor Gregory.

"It has been planned to have two separate and distinct buildings," he said, "connected only by a chain of medical offices and laboratories. The greatest care has been taken to plan these buildings so as to provide every facility for caring for patients according to their individual needs and conditions. Much thought has been given to the very important problem of segregation and to the classification of the patients according to the nature of their ailments.

"To carry out this idea it has been planned to have many rooms for one, two and for three patients and several small wards. Large wards have been discarded as being obviously unsuitable for the treatment of mental illness. In planning the hospital, every feature, even the decorations, has been considered from the standpoint of the curative effect upon the patient."

Patients whose illnesses are of brief duration will be kept apart from those suffering from more serious disorders, according to Doctor Gregory. The latter will include alcoholics, drug addicts, delinquents and potential criminals.

There will be a separate department for investigation and treatment of nervous and "problem" children, the work to be carried on in cooperation with the department of education.

A special research clinic also is being planned to investigate crime and criminal tendencies from a psychiatric point of view, this department to cooperate with the probation bureau and the courts of criminal jurisdiction. There will be a general research staff with complete laboratory equipment for investigation and preventive work among the mentally ill.



# Bed Space in Maternity Hospitals

## *A Discussion of Legal Minimum Requirements*

By S. S. GOLDWATER, M.D.

New York City

IT IS unfortunate that public authorities are not in agreement concerning the amount of space that should be provided for each patient's bed in maternity hospitals. In some localities minimum floor space is prescribed by law, while elsewhere the regulations specify cubic space only, a method of control that is not altogether without value but which allows almost too much latitude in the determination of floor areas, for by accentuating the height of the ceiling it is possible to provide all of the cubic space that is demanded, however liberal the allowance, and at the same time to crowd beds together in such a manner as to hamper the clinical service, lessen the comfort of the patient and increase the risk of infection.

In the formulation of rules of practice it is desirable to keep in mind (a) air supply, (b) clinical convenience of doctor and nurse, (c) air and bed contamination and (d) the comfort of the patient. Every essential need should be met but from the standpoint of social economy it is unjustifiable to spend more money in the construction of a hospital than safe and adequate service demands. Public regulations should guarantee safety but should scrupulously avoid extravagance, and it is for this reason that I venture to comment on regulations recently drafted by officials in an Eastern state who, sincerely desiring to perform a public service, propose to set up a minimum requirement of 100 square feet of floor space per patient in the wards of maternity hospitals. I do not think that the proposed regulation, however well intended, should be adopted, and I shall briefly explain why.

### *How a Four-Bed Ward Is Arranged*

By way of illustration, let me cite a type of hospital maternity ward that is now being widely used, which, so far as I know, is proving acceptable and which, so far as I can see, does not involve either danger or discomfort to its occupants. I refer to the popular modern type of four-bed ward, with, say, 20 running feet of outside wall and a depth of 16 feet. Along each side of the ward, in a space of 16 feet, two beds are arranged; this allows 8 feet of wall space behind

each bed. If in such a ward a space 6 feet wide is maintained between adjoining 3-foot beds, there will still be 2 feet of unoccupied space on the opposite side of each bed, and the bed will thus be accessible, for purposes of examination and treatment, from all sides. Is not 6 feet between beds ample?

### *Satisfactory Ventilation Is Possible*

In such a ward the patients are far enough apart for safety and comfort. Privacy may be established by the introduction of curtains or of cubicle partitions (curtains preferably, since two of the four beds do not adjoin the window). If the ward is provided with, say, two 4-foot windows and with a door and transom opposite the windows (between the ward and a cross-ventilated corridor), satisfactory conditions of ventilation can be maintained—especially if the window detail be properly worked out—without artificial ventilation. Add a system of exhaust ventilation (mechanical supply would complicate matters too much), and the conditions are still further improved.

Such a ward, however, would have only 320 square feet of free floor space for the accommodation of four beds, or 80 square feet per bed. With a ceiling 10 feet in height, the ward would provide 800 cubic feet of space per bed, which is the legal requirement in a number of states. An 11-foot ceiling would increase the cubage to 880 feet per bed, or 10 per cent more than the law, in some localities, calls for. A more spacious ward would add an element of luxury, which may properly be considered when the cost of construction and the cost of maintenance are so generously provided for by private funds that economy may safely be disregarded. Such conditions are rare, however, and public authorities should think twice before adopting the most liberal sort of private practice as the basis for legal minimum standards. It cannot, in my opinion, be successfully shown that there is any indispensable need for a more liberal spacing of beds or a more liberal air space allowance than is provided in such a ward as I have described.



In attempting to judge the point at issue we should bear in mind that during much of the time the door of such a ward as I have described is open, that the adjoining corridor is or should be cross ventilated and that the occupants of the ward do in some measure profit by the air space of the adjoining corridor.

The consideration of internal ward conditions without full attention to surroundings never presents a fair picture. I have seen wards liberally spaced in which the conditions were infinitely worse than in wards containing a smaller unit allowance of floor space and of cubic space, because of other aspects of the plan. One might, for instance, have plenty of floor space combined with poor exposure to sun and air and no cross ventilation. This would be less advantageous to the patient than a smaller allowance of floor space with a better environment.

Nowadays physiologists do not stress mere air supply or atmospheric volume nearly as much as they stress air conditions, namely, temperature, humidity and air movement. Legislation based on conditions of space alone does not satisfactorily reflect the modern scientific viewpoint.

Entirely apart from the question of atmospheric conditions, there is a certain minimum of floor space required to facilitate the movement of doctors and nurses about the bedside, and the separation of beds from each other is, of course, desirable in the interest of the patient's comfort. I believe, however, that all of the basic needs can be and often are fully met in well planned wards which allow 80 feet of floor space per bed, and I would therefore propose that this, rather than 100 feet, be adopted as a legal minimum. This does not, of course, imply that every plan that allows 80 feet of floor space per bed merits approval.

### The Student Nurse and Her Work in the Diet Kitchen

In most hospitals the staffing of the diet kitchen is usually inadequate. So much work is to be performed there and the stress under which it is done is so great that few institutions are entirely satisfied with the adequacy of their dietetic departmental personnel.

In every hospital with a training school a certain number of student nurses are assigned to the diet kitchen. In several institutions student nurses are expected to perform heavy work in the preparation of diets in the general kitchen. To expect such a service from students in training is unreasonable. The student nurse is assigned to the diet kitchen largely from an educational angle. Too often nurses are allowed to enter the practice of their profession who are unable to demonstrate a knowledge of the basic principles necessary to the preparation of palatable food. If a student nurse is required continually to perform routine duties in the diet kitchen at the ex-

pense of her education she is being treated unjustly. The principle which should be followed here is that her presence in the diet kitchen is fortunate if both a utilitarian and an educational aim can be met. If one must suffer, the educational requirement should predominate.

### Lest Others Be Imposed Upon—

The following letter from a hospital superintendent has been received by the editor of *THE MODERN HOSPITAL* and is printed here in the hope that it may protect some other hospital from an imposition similar to that experienced by this Southern hospital:

"During the month of December a man came into my office purporting to be a Doctor Hubbard from Louisiana. He told me that this was not his correct name but it was the name he desired to go under. He said that he had been caught in the dope habit for about eight weeks and desired to get relieved from same. He asked us to call our staff doctor to treat him, and said that he would pay his bill when he was dismissed from the hospital. He ran up quite a bill at our drug store and failed to pay his special nurse and left one morning without saying anything about his hospital bill.

"While in the hospital he secured \$27.50 from the Episcopal bishop who called on him, and \$15 from an Episcopal rector who called on him. He told us so many different tales that I got suspicious and when he saw that my suspicion was aroused he left."

### The Need for Better Supervision of Midwives and Private Hospitals

The health inventory made recently by the Welfare Council of New York City cites a recommendation for more careful examination and supervision of midwives contained in the hitherto unpublished report of the American Public Health Association appraising the work of the New York City Department of Health. The Welfare Council inventory says there were 1,262 licensed midwives in New York City in 1927 and adds that "to many of these midwifery is an avocation." There are 10,900 licensed physicians in New York City, but the proportion of these available for obstetrical service is unknown, the report says.

While small privately conducted hospitals were not within the scope of the health inventory "facts brought out incidentally in the course of the inventory," the report says, "suggest the need for the fuller use of the inspecting and licensing powers of the department of health over the proprietary hospitals and nursing homes, many of which take maternity cases."

A large proportion of the staffs of maternity hygiene agencies volunteer their services it is revealed by the health inventory. Only nineteen of the 204 doctors in this field are paid for their services. It is estimated that if these doctors and other volunteers in this work, exclusive of students and nurses in training, were paid for their services the total salary bill would be approximately \$220,000 annually.

The visiting nurse plays an important part in the maternity services, the inventory shows. Nurses from prenatal clinics made some 63,000 visits in one recent year and in addition the several nursing organizations reported 157,000 home visits to maternity patients attended by private doctors and midwives.

# How One Hospital Reduced Its Fire and X-Ray Hazards

By A. C. ECHTERNACHT, M.D.

Director, X-Ray and Physical Therapy Departments, Methodist Hospital, Indianapolis, Ind.

THE x-ray department of the Methodist Hospital, Indianapolis, Ind., is the outgrowth of the remarkable progress of that institution. When the hospital was founded in 1908, it had a capacity of about sixty-five beds. Since then the capacity has been increased to 600 beds by the addition of buildings and the installation of modern equipment.

Such rapid and substantial growth made it necessary that the x-ray, physical therapy and clinical laboratory departments of the hospital keep pace with the rapid development of other departments. As a result, the present service unit was erected. It is a modern reinforced concrete structure, five stories high, the second floor of which is devoted to x-ray and physical therapy. No effort or expense has been spared in equipping this unit throughout. Without doubt many of the technical and safety features incorporated in the x-ray department will be of interest to those planning new hospitals, and for that reason a brief description of the equipment and arrangement is given here. The floor plan is shown in Fig. 2.

The x-ray office and dictation room contain all metal filing cabinets for approximately six weeks' supply of current films, with a limit of 250 pounds. They also contain stereoscopes and film viewing cabinets.

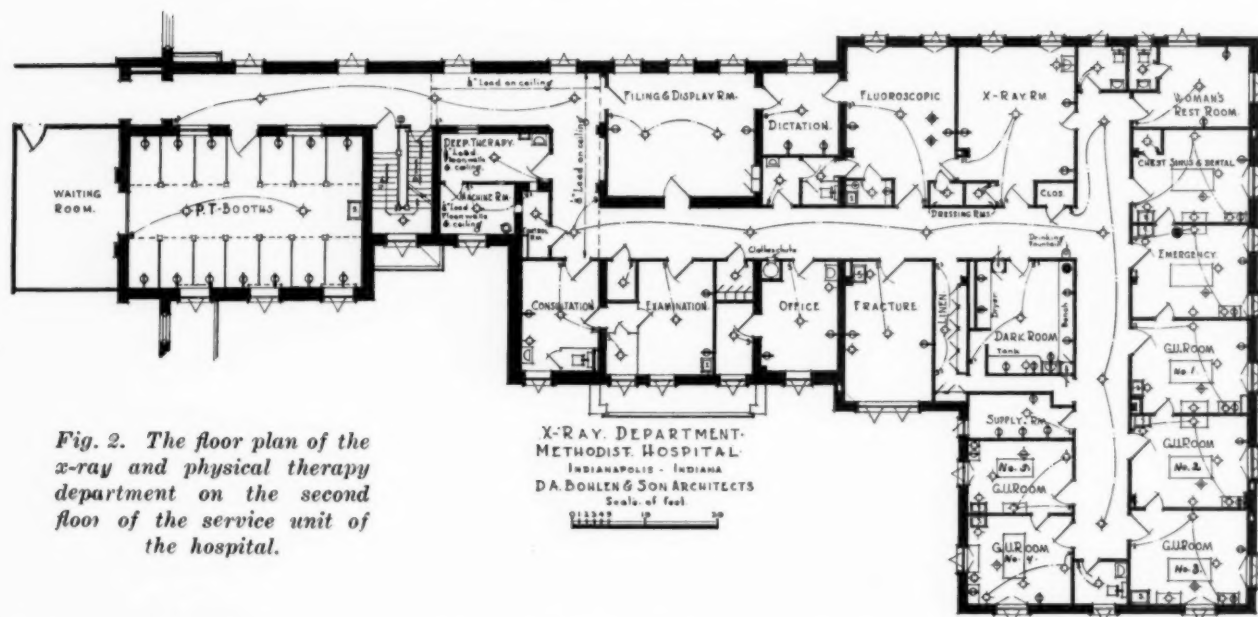
The equipment in the gastro-intestinal room, shown in Fig. 2 as the fluoroscopic room, is a motor driven, tilt top table with a built-in Bucky diaphragm, fluoroscope and tube stand rail running the full length of the table. This room is energized by a 120,000 peak volt transformer of the double disc type of rectification.

## *How the Rooms Are Equipped*

The radiographic room, designated as the x-ray room (Fig. 8), is equipped with a flat top table that has a built-in Bucky diaphragm running the full length of the table. A side rail also carries a tube stand the full length of the table. A plate changer is placed in a position that permits ten-foot radiograms when necessary. A mastoid apparatus, so constructed that the patient does not lie on the painful ear, is part of the equipment in



*Fig. 1. This exterior view of the vault used for storing x-ray films at the Methodist Hospital, Indianapolis, shows the excellent outside ventilating system.*



this room. The tubes are energized by a 140,000 peak volt transformer of the double disc type of rectification. If necessary, this transformer can also energize the tubes in the gastro-intestinal room.

The room for the treatment of the chest and sinuses and for dental treatment is equipped with a new type combination tube and cassette changer. As the cassette changer is raised and lowered to the height of the patient, the tube automatically moves with it. This keeps the tube at all times properly centered on the cassette. The tube stand has an automatic device for resetting the tube after the second film of the stereo set is made. The sinus apparatus, with the tube supported at a constant distance from a Bucky diaphragm, is so arranged that films may be exposed from any angle for all sinuses. This whole apparatus may be raised or lowered in the same manner as a tube on a tube stand. The tube and Bucky diaphragm may be placed in any position, revolving by means of a swivel joint through a complete circle. This

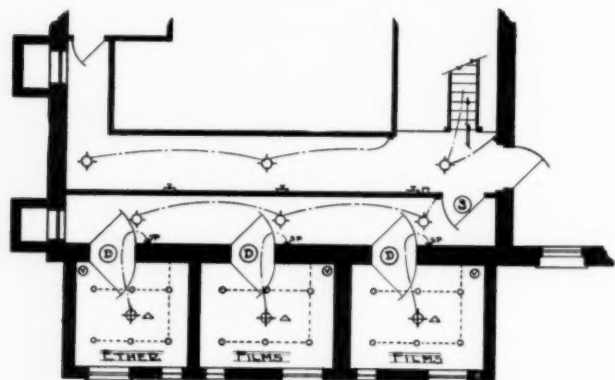


Fig. 3. A well planned system of ventilation and an automatic sprinkling system are features of this vault used for the storage of films.

feature permits the taking of sinuses or mastoids from the proper angle whether the patient is sitting upright or reclining.

In the cystoscopic department, designated in the floor plan as G.U. rooms Nos. 1, 2, 3, 4 and 5, there are three cystoscopic tables in rooms Nos. 1, 2 and 3 (Fig. 6), equipped with stereo-shift x-ray tube holders and built-in Bucky diaphragms. The cystoscopic room No. 1 is energized by the same transformer that activates the tube in the emergency room. The tables in Nos. 2 and 3 are energized by a 100,000 peak volt transformer of single disc type of rectification. A new feature of one of the more recently purchased cystoscopic tables is that the table may be changed from the Trendelenburg to an upright position by motor power. Shockproof rheostats to regulate the voltage passing through the cystoscope are conveniently attached to all three tables.

The dark room, accessible from all points, is equipped with monel metal lined insulated tanks containing an earthen developer tank, a fixing tank and an acid bath. The water temperature is regulated by thermostatic control. Illumination is provided by safety lights. Heated air from the electric oven is exhausted through the main ventilating system so that air passing over the films is not inhaled by those in the department.

The fracture room contains no high tension overhead installation. The equipment of this room is a specially built combination fracture and x-ray table with an aluminum top. Beneath the table is a small transformer which can be moved the full length of the table. A 30 mm. radiator type tube is immersed in oil inside the transformer casing. A similar transformer is also built on a stand, adjustable for any height, which may be moved





Fig. 4. These tin clad fire wall doors between corridor and compartment have fusible links and self-closing devices.

to any portion of the table for a lateral fluoroscopic view without moving the patient.

The transformer room, designated in the floor plan as the machine room, is equipped with a 230,000 peak volt transformer with a double disc type of rectification, a 50 m.a. water cooled tube, a stabilizer, a sphere gap and a water cooling system. In the control room a dosimeter permits the operator at all times to note the quality and quantity of the x-ray reaching the patient and serves as a check on the filters. The tube may be operated at 200,000 k.v. and from five to fifty milliamperes. It occupies a position inside the machine room opposite a 25 cm. port in the partition between the patient's room, shown on plan as deep therapy, and the machine and tube room. The port has variously sized removable shutters that change the size of the port, thus enabling a small or greater area to be treated. The ioniza-

tion chamber of the dosimeter is securely interposed between the tube and the patient, and when filters are used they are placed between the tube and the ionization chamber.

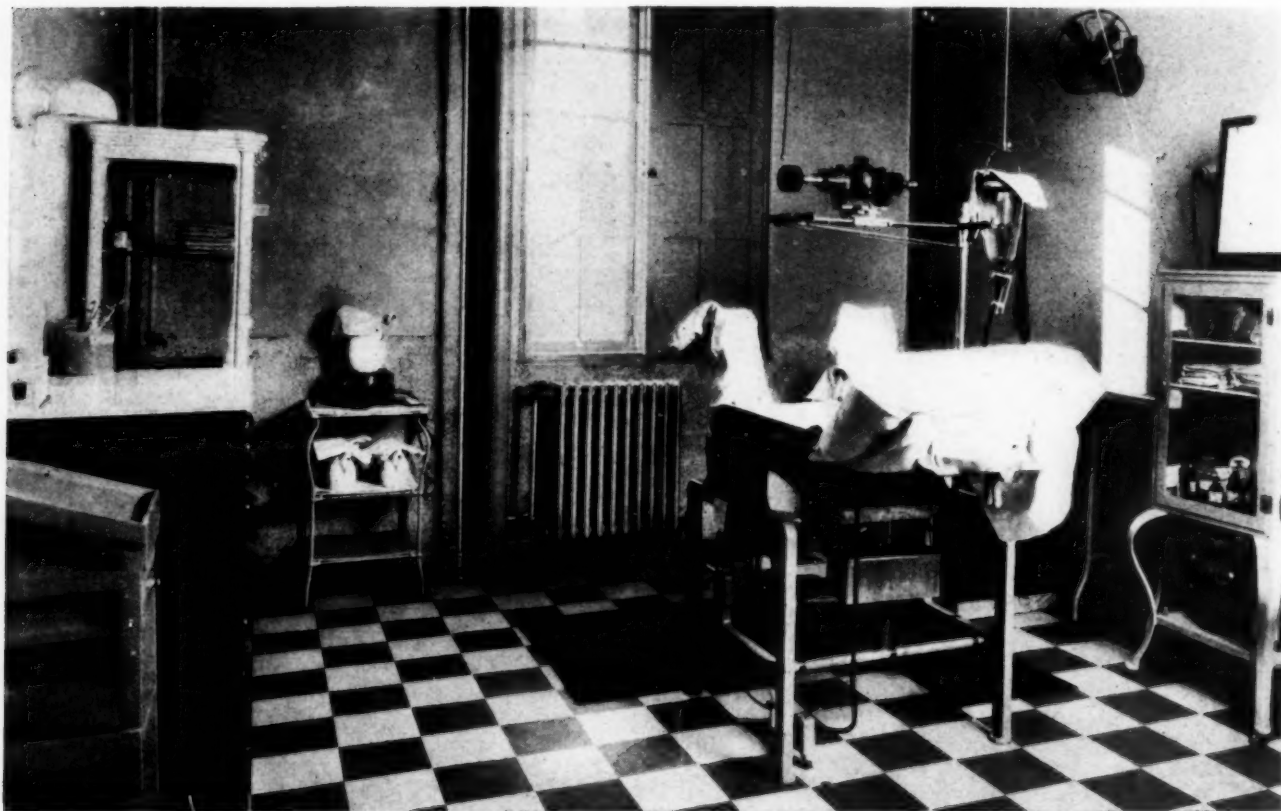
The machine and tube room walls and partitions are lead lined, to a height of seven feet, on both sides with sheet lead weighing eight pounds to the square foot. Walls above this height and ceilings are lined with lead, four pounds to the square foot. By the mere throwing of a high tension switch operated from the booth, the current can be changed to a lower voltage overhead system in the patient's room which may then be connected to an eight-milliamper tube mounted on a movable stand, for lower voltages.

#### *Rubber Tile Used on the Floor*

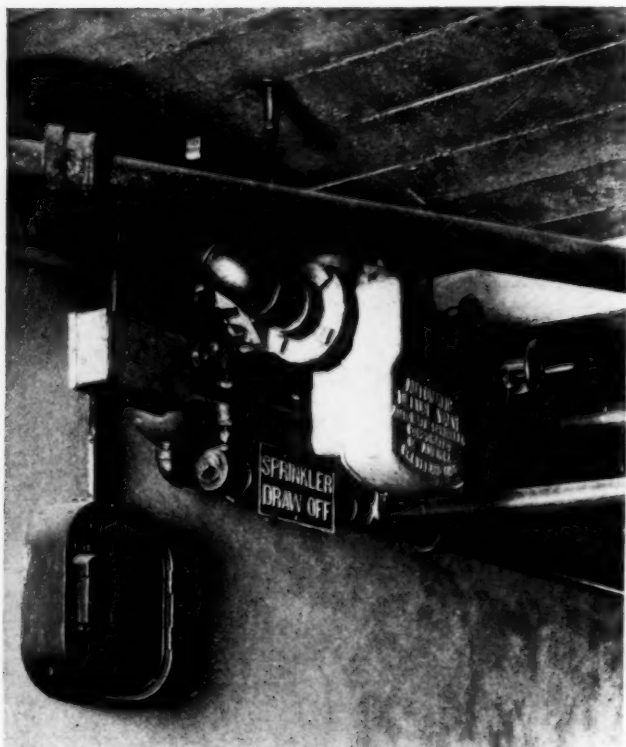
The floors of all the rooms are covered with rubber tile in checkerboard pattern which is both pleasing to the eye and restful to the feet. This flooring also has the added advantage of being an efficient noise absorber and has proved an excel-



Fig. 5. Danger signs have been painted on the compartment doors along the corridor in front of the vault. The doorway to the tunnel is shown at the extreme end on the left, while two vault compartment doors are seen on the right.



*Fig. 6, shown above, is a view of a cystoscopic room. Fig. 7, below, shows the water supply in the corridor outside the vault. Automatic deluge valves and a manual pull box are seen.*



lent safeguard against electric shocks. All low tension electric connections are brought through the floors beneath all tables and the conduits are carried a sufficient distance above the floor to prevent moisture from entering them. All overhead high tension tubing is finished in chrome nickel. All installations have stabilizers. Each x-ray room is equipped with a lead chest for loaded cassettes. An intercommunicating signal system is provided to facilitate the efficient handling of patients and to make communication easy between the director and the various assistants.

#### *The Method of Film Storage*

In the film storage vault extraordinary precautions have been taken to safeguard hospital property against the hazards of fire incident to the storage of x-ray films. In doing this, a separate and distinct unit has been provided. The film storage vault (Fig. 3) is about 120 feet from the hospital proper and is accessible by means of a 150-foot tunnel that connects the vault and the hospital, with three automatic fire doors intervening. These doors are kept locked except when someone is in the film vault. The vault is of reinforced concrete construction and is divided into three compartments by reinforced concrete walls without communicating openings. Each compartment has natural ventilation provided by louver windows in one wall and by metal ventilators extending twenty feet above the room (Fig. 1). On

the top of each vent is a revolving head. The entrance to each compartment from the corridor is protected by two tin clad, fire wall doors equipped with fusible links and with heat actuated self-closing devices (Fig. 4). The corridor running in front of the film vault was designed as a special precaution (Fig. 5).

Only one doorway leads from this corridor to the tunnel and this opening is also protected by a fire wall door with self-closing devices. The electric light bulbs are surrounded by vaporproof globes protected with wire guards. A series of automatic pilot lights are so arranged that a red light shows conspicuously whenever a light in the film vault or passageway is left burning. These vaults are locked with heavy padlocks, and keys are available only to authorized persons who must sign a register before they receive the keys. Danger signs and signs prohibiting smoking are conspicuously posted.

Each of the three storage compartments is protected by an automatic deluge system which is designed to flood the space with a uniform spray of water if at any time the temperature should rise at a rate in excess of 15° F. per minute. This

system differs from the usual automatic fire extinguishing systems in that it is not actuated by the fusing of a metal or by other means requiring the temperature to attain a predetermined point. It is operative at any temperature caused by a sudden rise above normal. This is essential since the temperature in the vault approximates that of the outside air because of the large ventilating openings through the outside walls and because of the absence of any heating facilities.

#### *Adequate Protection Against Fire*

Within each vault compartment are six specially designed sprinklers or distributing heads, each designed to distribute a uniform spray of water that thoroughly drenches the ceiling, walls and contents of the compartment and each covering an area of sixteen to twenty square feet of the ceiling. The six sprinklers in each vault are supplied through an independent deluge valve and a two-inch supply pipe and will discharge about 200 gallons of water a minute. The cooling effect of the spray on the ceiling and the solid masonry walls separating the vaults will effectually prevent the transmission of heat and thus confine the fire

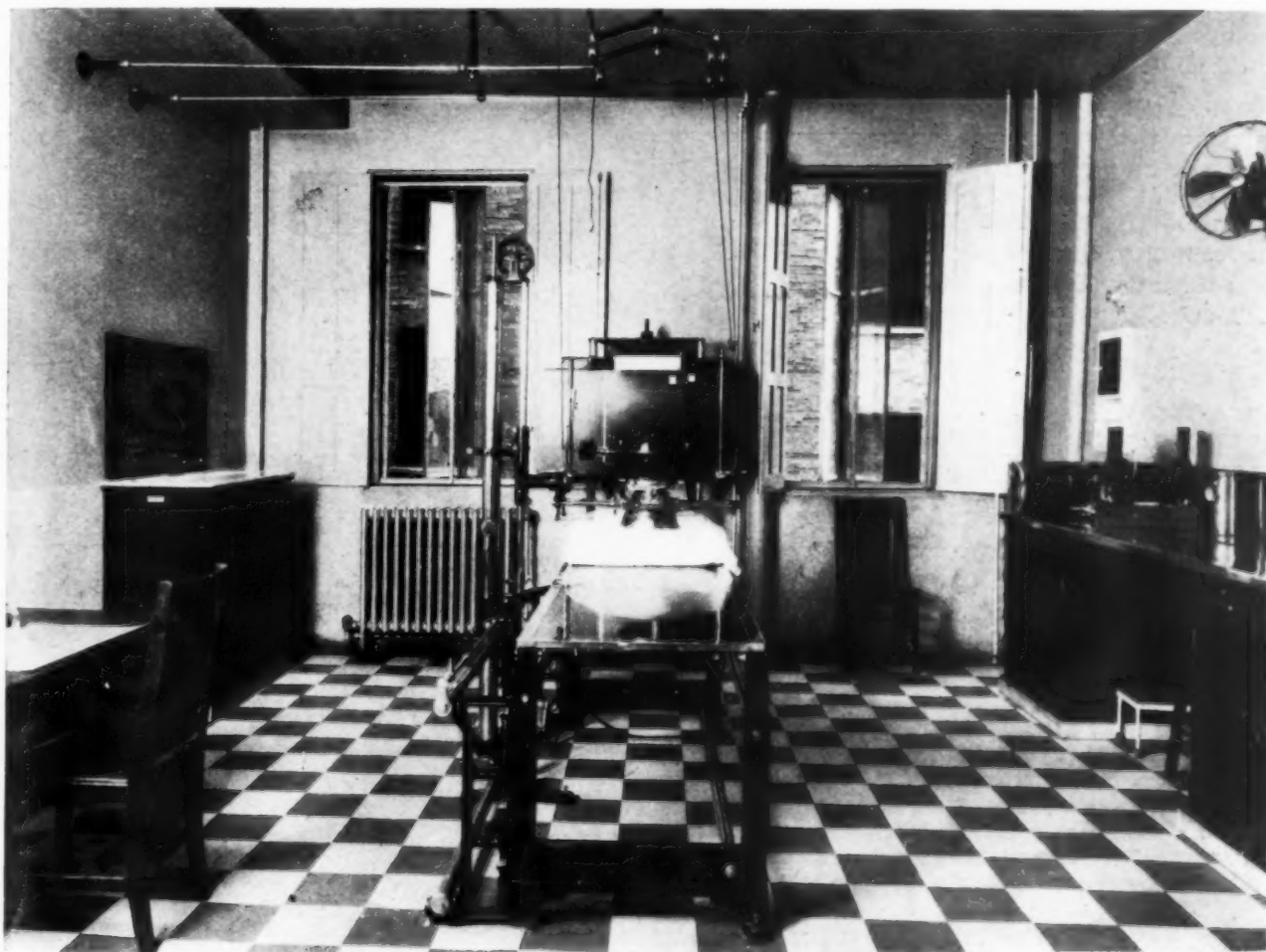


Fig. 8. A flat top table, a plate changer and a special apparatus for mastoid work are part of the equipment in the radiographic room.



and flooding to the compartment in which the fire occurs. The water supply to all three deluge valves is taken from a six-inch service line fed by a twelve-inch city water main under fifty-five pounds pressure.

When the system begins to operate in any of these vaults, an electrical attachment on each deluge valve operates an alarm bell in the adjacent power house and also a red lamp on the telephone switchboard in the main building. An alarm is immediately transmitted to the fire department. In addition to this automatic protection, there is also provided on the outside of the corridor at the front of the vault a manual pull box (Fig. 7), suitably guarded against tampering, so that in an emergency either of the vaults may be flooded manually.

This vault installation was brought about as a result of the special hospital service campaign given to all hospitals in the United States and Canada by the stock fire insurance companies through the National Board of Fire Underwriters and the fire insurance rating organizations.

It should be interesting to those responsible for hospital expenditures to know that by providing a safe storage place for nitrocellulose films, by installing fire extinguishers, by removing maintenance shops to a detached building and by making other improvements, the Methodist Hospital has been able to obtain liberal reductions in its insurance rates. With these reductions, combined with the even greater reductions allowed for because the hospital carries sufficient insurance to value, the insurance rate is now nearly 80 per cent lower than when the hospital started its intensified fire prevention campaign.

### Health Insurance Organizations in Austria—Their Effect on the Clinics

With the development of health insurance organizations in Austria, the whole question of out-patient departments has undergone a change. Dr. Julius Tandler, commissioner of health, hospitals and public welfare, Vienna, Austria, stressed in a paper presented at the meeting of the American Hospital Association, Atlantic City, June 17-21, 1929. Doctor Tandler explained the functioning of these organizations as follows:

The health organizations assure their members free medical service, free medications and free burials. If a member loses his weekly wages because of illness, he receives sickness insurance money. The organization also gives insurance money to pregnant mothers six weeks prior to the birth of the child and six weeks afterward. If the mother nurses her child for a period of twelve weeks she is entitled to a nursing mother's award. In addition, the health insurance organizations have established special hospitals for tuberculous patients, convalescent homes and maternity hospitals.

The Health Insurance Organization of Vienna has a membership of 440,000. When the families of the members are considered, this number affects approximately 1,000,000 persons. It is estimated that between 70 and 80 per cent of the citizens of Vienna are insured. The Working Men's Health Insurance Organization alone employs 446 salaried physicians.

The health insurance organization has established twenty-three completely equipped out-patient clinics. Last year 82,000 patients received medical care at these clinics each month. The perfection of these departments is constantly going on. For this reason, the out-patient departments of the university hospitals are in danger of losing valuable clinical material for their teaching, especially since the health organization physicians are usually famous.

Contracts between the medical faculties and the health insurance organizations will be necessary if the problem is to be solved. Either the patients of the organizations will be obliged to go to the hospitals or else the professors and assistants will be obliged to teach in the out-patient clinics of the organizations.

### A Grouping of Health Agencies in One Building

The office building at 370 Seventh Avenue, New York City, is headquarters for some fifteen health organizations and allied activities, according to the *Trained Nurse and Hospital Review*.

It is the home of the American Nurses Association and of the National League of Nursing Education. Groups that coordinate their activities in the National Health Council include the American Child Health Association, American Heart Association, American Public Health Association, American Social Hygiene Association, National Committee for Mental Hygiene, National Society for the Prevention of Blindness, National Organization for Public Health Nursing, National Tuberculosis Association and the Woman's Foundation for Health.

Allied organizations in the building are the Child Health Demonstration Committee, Circle for Negro Relief, Women's Division of the National Amateur Athletic Federation, National Council of Women of the United States, National Probation Association and the President's Committee of Fifty on College Hygiene.

The National Health Council also includes as advisory members the American Red Cross, the United States Children's Bureau and the United States Public Health Service.

### Improved Lighting Systems in Paris Hospitals

The prefect of police of Paris has decided to install a subsidiary autonomic lighting system throughout the hospitals of the prefecture to provide against breakdowns in the electric lighting service. An appropriation has been secured from the municipal court to permit the installation of an emergency lighting system in the operating rooms, the wards of the surgical service, the maternity service and the rooms reserved for consultations, the *Journal of the American Medical Association* states.

# How May the Hospital Prevent Accidents to Patients?

By MORRIS HINENBURG, M.D.

Assistant Director, Montefiore Hospital, New York City

A HOSPITAL is an institution for the care of persons diseased in body or in mind. These persons enter a hospital for the care and relief of their ailments, confident that all facilities to effect this purpose will be available for application by skilled medical and nursing personnel.

A proper physical arrangement of an adequate plant and its equipment and a well organized and coordinated working staff are necessary if the hospital is to serve the best interests of its patients. Other phases of hospital activity are of little or no concern to those who are seeking to regain their health within the institution. Any occurrence harmful to a patient that is not in keeping with the foregoing definition may be termed an accident for the purpose of this study. Malfunctioning of any hospital department constitutes a hazard. Such accidents, like most others, are preventable.

Accidents are frequent in all normal daily activity and there are constant investigations by the authorities to determine their cause and prevention. Airplane and traffic accidents, shipwrecks and industrial accidents are matters of everyday occurrence and have commanded more attention than minor accidents, even though the latter in the aggregate have a larger casualty roll. The problem is not a difficult one to solve. Hospital accidents are preventable.

## *Exhaustive Investigations*

Recent tragedies on a large scale in hospitals have brought about exhaustive investigations with the object of securing fire resistive buildings and adequate fire fighting facilities if these should be required. Modern building codes are planned to safeguard the community. Fire escapes, fire-proof stairways, automatic fire doors and sprinkling systems should be included in the equipment of every institution. Material damage would appear to be less costly than the means taken to prevent it if it were not for the fact that human life and happiness are involved. But the truth of this statement would not be sufficient to start the installation of a reasonable quantity of safety

devices. The power of legislation, therefore, must be invoked as an aid.

The minor accidents and even the larger tragedies that occur in hospitals cannot altogether be controlled by legislation although they are definitely subject to control by prevention. This can best be accomplished by the coordinated cooperative efforts of a hospital personnel that is conscious of the fact that all accidents with their sequelae are worthy of every effort to prevent them. The trustees of hospitals are ambitious to render better and better service to lighten the community load of disease and even of hospitalization in order that the return of the patient to health may be accomplished as speedily and effectively as the clinical circumstances permit. This service will be greatly improved when hospital accidents are reduced to a minimum.

## *A Study of One Hundred Accidents*

This survey represents a frank study of a series of 100 consecutive accidents that occurred at Montefiore Hospital. A rigid investigation of all accidents based on written evidence was instituted. I shall try to indicate from the information gathered, the general nature of the most common accidents, their cause, their frequency and the measures taken to prevent them.

The following is a general classification of these 100 accidents and their immediate causes, as well as the number of accidents of each type:

Falls from bed, 49 per cent: weakness and restlessness of patients during waking hours, 21; weakness and restlessness of patients during sleep, 5; psychosis, 3; patients leaving bed without waiting for assistance, 4; overreaching, 4; bed patients left unattended on bedpans, 4; carelessness in changing bed linens, 4; patients leaving bed against physicians' orders, 2; faulty bed set-ups, 2.

Falls from wheel chairs, 20 per cent: overreaching, 5; overturning (collision), 8; restlessness, 2; leaving chairs without assistance, 5.

Falls while walking, 13 per cent: sudden attacks of dizziness, 3; sudden weakness, 3; epileptic attacks, 3; awkwardness, 3; fright, 1.

Falls in toilets, 4 per cent: paralytics left unattended in toilets, 4.

Burns from hot water bags, 3 per cent: carelessness in applying hot water bags to patients with sensory disturbances, 3.

Falls in bathtubs, 4 per cent: patients left unattended, 4.

Suicide, 1 per cent: acute melancholia, 1.

Attempted suicide, 1 per cent: senile psychosis, 1.

Broken hypodermic needle, 1 per cent: sudden convulsive jerk of patient, 1.

Injury by falling window, 1 per cent: broken sash cord, 1.

Burns by hot fluids, 1 per cent: overflow of hot tea in cup, 1.

Falls in bed, 1 per cent: careless handling of bed patient (pathological fracture), 1.

Overdose of drug (without knowledge of physician), 1 per cent: 1.

The patients admitted to Montefiore Hospital are of the chronic type, presenting problems in diagnosis or requiring prolonged medical and nursing attention. They are more or less bedridden and require a specialized form of attendance. These patients remain at the hospital as long as medical attention and nursing care are required, and the patient's stay is often protracted. This has a definite influence on the accident rate.

In our study it was found that 46 per cent of the accidents occurred to in-bed patients, 28 per

Hemiplegia .....	23
Carcinoma .....	19
Cardiac disease .....	10
Diabetes mellitus .....	8
Tuberculosis .....	6
Arteriosclerosis .....	5
Paralysis agitans .....	4
C. N. S. syphilis .....	3
Degenerative chorea .....	3
Brain tumor .....	3
Dystonia musculorum .....	3
Multiple sclerosis .....	3
Psychosis .....	3
Chronic anterior poliomyelitis .....	2
Osteogenesis imperfecta .....	1
Generalized dermatitis .....	1
Amaurosis .....	1
Spinal cord tumor .....	1
Myasthenia gravis .....	1

cent to wheel chair patients, 17 per cent to ambulant patients and 9 per cent to semiambulant patients. Those who are bedridden include paralytics, cases suffering from advanced cachexia,

cardiac and tuberculous cases, crippled diabetics and cases of generalized arteriosclerosis. The accompanying list is a clinical classification of the accidents in this series. These cases are considered only in the groups indicating the major conditions without regard to their complications.

Forty-five per cent of the hospital beds are occupied by female patients, but accidents to female patients were proportionately greater, 59 per cent; 62 per cent of the accidents occurred to patients with impaired mentality and 38 per cent to patients apparently in possession of their mental faculties. According to age groups, one patient was under 10 years of age, seven patients ranged in age from 10 to 20, twenty-one from 20 to 40 and forty-three from 40 to 60 years. Twenty-eight were over 60 years of age.

#### *Where the Accidents Occurred*

There is an equal distribution of patients in the various wards and rooms of the hospital, one-half being accommodated in large wards arranged for eight, fourteen and seventeen beds, and the other half in single and double rooms and rooms with four and five beds. Thirty-five per cent of the accidents occurred in the former group and 53 per cent in the latter group, these accidents occurring within the room, 5 per cent in the utility rooms and toilets, 5 per cent in the corridor and 2 per cent on the hospital grounds. Seventy-four per cent of the accidents were witnessed by members of the hospital staff.

Falls from bed constituted 49 per cent of the accidents. The type of patient treated here has some relation to this figure, while the character of the employees and of their work also plays a part. Many of the patients are condemned by chronic and sometimes incurable disease to lead an almost vegetative existence. The malady in 62 per cent of these cases has brought about not only physical deterioration but also mental and spiritual changes which make it difficult if not impossible for the patient to cooperate voluntarily with physicians and nurses. These patients become more restless as their confinement is prolonged and they are not easily reconciled to their lot. Their activities must be supervised all the more for these reasons and must, when occasion requires, be restricted by physical means to save them from bodily harm.

Physical disease is not always accompanied by serious mental changes (38 per cent in our series are so classified) but in this group restlessness and the intensity of the struggle for life during prolonged illness stimulate the patients to attempt activities beyond their powers. They naturally grasp at every opportunity to recuperate.



Delay on the part of the attendants may lead to discomfort and may prove fatal. Patients will help themselves when others will not help them or when they give their services grudgingly.

#### *When the Accidents Occurred*

In our series, most of the accidents occurred during the day, 54 per cent between the hours of 7 a.m. and 7 p.m. and the remainder during the night, numbers which seem out of proportion, since all hospital activities are almost at a standstill during the night in a hospital like Montefiore. Twenty-nine per cent of the accidents occurred between 1 and 7 o'clock in the morning and, strangely enough, the greatest number for a single hour, 8 per cent, occurred at 4 a.m. Thirty-five of the forty-nine falls from bed occurred during the night.

Some of the patients fall from bed during sleep, usually in an attempt to assume a more comfortable position. Certain patients are permitted bathroom privileges in order to encourage activity. These patients are, as a rule, assisted by an attendant, but occasionally they leave their beds unassisted and fall during a period of exhaustion before they can summon help. Several patients in our series disobeyed their physicians' orders to remain in bed and came to harm; others overreached themselves and fell. Bed patients are sometimes left on bedpans unsupported and unsupervised, with disastrous results. The carelessness of attendants in changing bed linens was responsible for a number of accidents in which patients were suddenly projected from bed when the linens beneath them were withdrawn. Severe cardiacs suffering from orthopnea, in their efforts to secure respiratory comfort, often prefer to sit upright and several of these cases, weakened by long periods in bed, fell when proper support was lacking. In two cases beds have collapsed under the patient's weight because of faulty set-ups.

#### *The Cause of Wheel Chair Accidents*

Approximately 250 of our 600 patients are up and about in wheel chairs. This is encouraged as soon as the condition of the patient permits activity, and it will in many instances prevent such serious complications as bed sores and the dreaded terminal pneumonias. A certain number of falls, under the circumstances, may be reasonably expected with such a large group of patients moving about in chairs. They can be seen wheeling themselves through corridors into elevators and about the grounds, some of them attended, many of them unattended. Wheel chair cases constitute approximately 40 per cent of

our hospital patients, and this group accounted for 20 per cent of the total number of accidents. A study of the causes indicated that overreaching for objects, overturning due to overactivity or faulty activity, the restlessness of certain neurological cases (such as the degenerative choreas) and transferring from chair to bed without assistance were responsible for all wheel chair mishaps. Negligence on the part of attendants was clear in those accidents where the patient was unable to sit up without support.

A number of accidents occurred to patients who had been ambulant for long periods. One of these had a sudden attack of dizziness and weakness, another had an epileptic seizure, a third stumbled. A normal person under these circumstances overcomes the obstacle, as a rule, but the patient does not. One patient, while walking to the toilet during the night, fainted when he suddenly encountered the night watchman making his rounds.

#### *Constant Supervision Necessary*

Supervision must be adequate and constant. The absence of such supervision was the direct cause of injury to partially paralyzed patients who had been left alone in lavatories. Ignorance of the attendants and carelessness alone were responsible for burns by hot water bags to patients with sensory disturbance. Overdosage of a drug, dispensing the wrong drug or any drug without a physician's order, preferably written, are offenses that are unforgivable. The result may be serious, as in the case of a sleepless patient whose respiratory capacity was embarrassed by an extensive bilateral tuberculosis and who was given an overdose of a sedative without a doctor's order.

Ten per cent of the accidents in our series occurred to patients with special nurses, usually when the nurse was out of the room and no substitute had been provided. The carelessness of the patient was responsible for 22 per cent of the accidents and the lack of proper equipment for 2 per cent. In 15 per cent no blame could be attached to anyone because these accidents could not be foreseen as, for example, in the case of an ambulatory patient who suffered an epileptic attack.

Hypodermic needles may be broken during the course of an injection given according to the best approved technique, but even here care in the choice of a needle and a kindly caution to the patient to cooperate will reduce the number of such accidents. Attendants must exercise care in handling hot fluids, both for their own safety and that of the patient. Accurate thermometers must

be used when water is drawn for a bath or when various irrigations are prepared.

Operative cases should have a careful physical examination to prevent the dreaded death on the table. Postoperative cases must not be left unattended. One brain case in our series was found walking about the ward less than eighteen hours after operation, but through some kind fortune suffered no serious effects.

#### *Attempts at Suicide Are Common*

Attempts at suicide are not uncommon. In the cases studied, supplemented by reports of other cases not included, it was noted that patients with suicidal tendencies gave almost pathognomonic signs by peculiarities in their behavior. Suicidal attempts may be frustrated if these action changes are noted and correctly interpreted by those in attendance. Individuals showing any alteration in their daily behavior must be supervised and restrained until there is a satisfactory explanation of the change that could serve as a basis for further action.

Scrupulous care must be given incontinent and bedridden patients to prevent the development of bed sores. Bed sores are accidents and are evidences of thoughtless nursing. Bedridden patients must be handled gently; one patient suffered a fracture of the arm at the site of a carcinomatous metastasis when attendants raised her and then let her fall back without support.

An unusual experience in a hospital is the disappearance of a patient. One such case, not included in the series, was a man 65 years of age who had recovered from a hemiplegia but retained a residual motor aphasia to indicate his cerebral insult. He was admitted to the ward in the routine manner, but for some reason the nurse in charge failed to have him prepared immediately for bed and when she looked for him he was gone. A search revealed that such an individual had wandered downstairs to the admitting office where, after the usual questioning of a new patient, a worker (the clerk who admitted the patient had left for the day) transferred him to another institution as a mental case.

Dietetic accidents, though uncommon, are worthy of mention. At Montefiore Hospital, a canteen is maintained for patients and personnel and is managed by one of our custodial patients under the close supervision of the administration. Food articles are on sale, but sales are limited to those patients who are on regular diets. Contraband food is occasionally brought to the patients by well meaning visitors. Because of careful supervision there have been no dietetic accidents from this source. The opportunity for

trouble in the dietetic department must however be apparent.

No accidents have occurred in this series that could be attributed to the weather or to the darkness of the night. The various diagnostic and therapeutic departments have been singularly free from mishaps. The radiographic, radiotherapy and physiotherapy departments use high voltage currents with apparent safety. The dental department treats approximately thirty patients daily without untoward accidents. The occupational therapy department, with its looms and machinery, has not yet reported any accidents.

This study has yielded a number of interesting observations, the most important of which is that no phase of hospital activity may be considered free from a certain definite relationship to the patient's welfare. Many hospital employees have no immediate contact with the sick, but this lack of direct contact does not remove the obligation to safeguard the patient's comfort. A faulty wheel chair or a faulty blood sugar analysis may undo all the months of careful medical and nursing attention. Proper safeguards must be systematically employed and inspected. Falls from bed can be prevented by the use of bed nets or side boards. (Here is a problem in hospital equipment which has not yet been solved satisfactorily.) Bed nets should be used for patients with impaired mentality who are restless and unmanageable. Side boards should be attached to the beds of patients who are helpless and restless but mentally clear. For patients who are restless only in sleep, the boards need be applied only at night.

#### *Instituting Safety Measures*

The nursing staff should be so organized that it is able to enforce adequate supervision over all patients and particularly over patients who are in a state of relative isolation in the smaller rooms. Patients who have been separated for their own comfort or for the comfort of the majority of the patients in a larger ward are apt to be overlooked. Patients' signals must be answered promptly. No patient may be left in the bathtub, since cases are on record telling of paralytics who were drowned or seriously injured when they were unattended. Nor may crippled patients be left in the lavatories. Efficient charge nurses can exact the proper performance of these duties by their subordinates. Regular rounds for the purpose of close inspection and check-up should be made by the administrative staff, deficiencies should be pointed out and adequate safety measures instituted to pre-

MONTEFIORE HOSPITAL  
Report of Accident to Patient

Date \_\_\_\_\_

Called at \_\_\_\_\_ a.m.  
p.m. by \_\_\_\_\_  
to see patient \_\_\_\_\_ in ward \_\_\_\_\_

Clinical Diagnosis: \_\_\_\_\_

History Given by Patient: \_\_\_\_\_

Additional Testimony of Others: \_\_\_\_\_

Physical Examination: \_\_\_\_\_

Diagnosis of Injury: \_\_\_\_\_

Treatment of Injury: \_\_\_\_\_

Prognosis of Injury: \_\_\_\_\_

Signed: \_\_\_\_\_ M.D.

This form should be filled out promptly  
and sent to the office of the director.

vent accidents. Most accidents are the result of poor management.

It has been our practice during the investigation of individual cases to focus the attention of the medical and nursing staffs on each accident, no matter how trivial. An accident always requires an explanation. It is an excellent administrative practice to have all accidents in the hospital reported to the office of the administration and made the subject of a special written report. Hospital functions and activities may be studied in the light of both the usual and unusual, and many valuable lessons may be learned. A hospital rule in force here requires a member of the house staff to attend the patient immediately in case of accident. The physician writes a complete

report on a special form. An investigation of all the circumstances of the accident is then begun, followed by recommendations. As a result of greater care, accidents in Montefiore Hospital have been greatly diminished in number and severity.

*The Hospital's Responsibility*

The interest of the medical staff in this subject should be maintained at all times. Preventing accidents to the sick is an important branch of preventive medicine. The spirit of prevention must be developed and maintained if the hospital is to fulfill its mission. Nothing can be more paradoxical than the case of a patient who suffers a setback or who succumbs as the result of a hospital accident. The administration of

MONTEFIORE HOSPITAL  
Report of Accident to Patient

Date \_\_\_\_\_

Dr. \_\_\_\_\_ called at \_\_\_\_\_ a.m.  
p.m.

to see patient \_\_\_\_\_ in ward \_\_\_\_\_

History Given by Patient: \_\_\_\_\_

Additional Testimony of Others: \_\_\_\_\_

Personal Observations: \_\_\_\_\_

Dr. \_\_\_\_\_ examined  
patient at \_\_\_\_\_ a.m.  
p.m.

Treatment Carried Out: \_\_\_\_\_

Signed \_\_\_\_\_  
Charge nurse.

This form should be filled out promptly  
and sent to the office of the school of nursing.



the hospital has a responsibility not only toward the sick for whom it cares but also toward the entire community. The community intrusts its sick to hospitals in good faith. The patients naturally share this feeling that every effort will be made to aid and cure them, and the hospital should strive to deserve this confidence.

The legal responsibility for hospital accidents is not clearly defined and it is at present impossible to state accurately just what constitutes legal negligence on the part of a charitable institution. Private hospitals operated for gain are held responsible for accidents to patients but in several decisions involving charitable organizations the courts maintained that such institutions incorporated for charitable purposes could not have their funds diverted to other uses. In other decisions, the courts have decided against hospitals when negligence was proved. The purpose of this paper, however, is to emphasize the moral rather than the legal obligation of the hospital to its patients.

### The Ideal Directorate for the Hospital

The ideal directorate of a hospital, according to Dr. Howard H. Johnson, medical director, St. Luke's Hospital, San Francisco, is made up as follows: the governing board of moderate size, ten or twelve members, divided into the executive committee, the finance committee and the building committee. These committees can handle all the work in any hospital. The members of the board must have business experience and ability as their first qualification. As to their special qualifications, a financier, a business executive, a lawyer, a philanthropist and a socially minded executive should be among the members—a church man, if the hospital is a church hospital. Women may occupy any of these positions.

Doctor Johnson spoke on this subject at the Western Hospital Association meeting, Portland, Ore.

### Smaller Units Make Possible Better Treatment of Mental Cases

That individualized treatment in mental hospitals is best carried on in the smaller units, was the opinion expressed by Dr. Mortimer W. Raynor, medical director, Bloomingdale Hospital, Bloomingdale, N. Y., at a meeting of psychiatrists at the Harvard Club in New York City.

One of the chief points brought out at the meeting was the necessity for handling mental patients in smaller administrative units. The points stressed were as follows:

That for the longer, or continued treatment cases, as well as for the more acute cases, individualized medical and other care remains necessary; that conditions involving primarily problems of personal readjustment cannot be met by impersonal methods; that in any institution there is a trend toward impersonal methods, which in-

creases with the size of the institution; that this trend is inherent in institutions and is inevitable and irremovable, and that while it may be measurably held in check by an alert and vigorous medical director who has a like-minded staff, yet on the least relaxation of vigilance and effort, it resumes its normal trend to tradition and impersonality.

### The Duty of the General Hospital Toward Mental Cases

General hospitals that provide psychiatric facilities are extending their services to the community in that they are making possible early treatment in nervous and mental ailments and thus are educating the public to look upon mental illness in the same way it regards physical illness, a bulletin issued by the New Jersey Department of Institutions and Agencies says.

Because the treatment and care for the mental patient are the same required for the average run of patients in general hospitals, all diagnostic and treatment facilities that are already an integral part of modern hospitals could be utilized in treating mental patients, the bulletin further emphasizes.

The type of patients that the psychiatric department of a general hospital would reach would include, according to the bulletin, those "nervous" persons who exhibit vague mental symptoms or anomaly of conduct and of feeling, or some specific problem of behavior in children, persons whose "nervousness" is often not severe enough to be regarded as illness yet whose condition makes it difficult for them to carry out life's normal activities; those who are seeking help in such troubles as fatigue, worry, jealousy, feelings of insecurity and mild mood changes; those who are overconscientious; those who expect "justice in the world;" those who meet the responsibilities of adults in a childish way; those who are good workers but who cannot get along with their fellow workers; those fathers who think they are right because they are fathers; those cases where mediation is needed between the conflict and ideals of two generations.

The psychiatrist would be consulted not only in those obvious mental cases that are referred to him, but also where behavior of peculiar types or unexpected attitudes interfere with medical treatment or prolong the illness; cases where the physical disorder is complicated by symptoms of functional nervous or mental disorders and cases in which no organic basis is found for the physical symptoms.

In establishing a psychiatric service in the general hospital, the community would be saved the expense that would be involved in establishing and maintaining a psychiatric clinic as a separate entity, the bulletin points out. The psychiatrists on the staff would be available for consultation and advice in connection with psychiatric problems arising in the local community. The medical student and nurse would be given an opportunity to study mental disorders and thus to secure valuable knowledge. The social service department could easily extend its services to psychiatric patients and thus help them to adjust themselves both socially and economically after they have left the hospital.

The bulletin lists also practical requirements for psychiatric departments in general hospitals and reproduces a number of plans of departments that are functioning successfully.

# Incidents That Create Unfortunate Staff Relationships\*

By EUGENE S. KILGORE, M.D.

Associate Clinical Professor of Medicine, University of California, San Francisco

**I**N ORDER to illustrate how complex and many-sided is the question of professional staff relations in a hospital let us consider some hypothetical incidents that might occur in any institution.

In a certain hospital a nurse, who was a friend of Doctor X, would on occasion mention his special skill to a patient of another doctor—casually, of course, and with the explanation that she was not supposed to mention such things and must not be quoted. The result was the frequent calling of Doctor X in consultation, with the subsequent transfer of the patient to his care, or direct transfer without consultation, a practice that was usually without benefit to the patient and often led certain doctors to feel that this hospital was undesirable.

In another hospital the resident physician was a protégé of a prominent surgeon. The young man was attentive to patients and was a "natural born go-getter." Soon doctors were heard quietly warning each other to beware of that hospital.

Another hospital contained many patients of Doctor A. Doctor B, an equally competent physician, sent a few patients to this hospital and became discouraged to find that soon after their admission they frequently dismissed him and became patients of Doctor A. Doctor B attributed these losses of practice not to any solicitation on the part of Doctor A or of the hospital personnel but to gossip between patients in the wards and in the solarium.

## *They Had Good Intentions but Little Skill*

The management of another hospital became painfully aware of unnecessary losses of health and life occurring in the institution, through the work of some of its professional patrons. If these doctors could have been proved guilty of criminal abortion or other frankly unprofessional conduct, it would have been simple to exclude them. But the perplexing fact was that they were members in good standing in the medical society and, as

far as could be proved, had good enough intentions but little skill.

Finally, here is the story of the hospital with a limited staff, depending for much of its patronage on other doctors. The superintendent's principal interest, aside from making the hospital "pay," was to augment the prestige of his friends and supporters on the staff. This interest, however, was not shared by many of the nursing and other personnel who at times in conversation with friends outside the hospital would mention favorably the name of a nonstaff doctor of excellent ability and reputation. Then these friends, previously no one's patients, would become patients of the nonstaff doctor, and the superintendent would hear how it happened and would express his displeasure. Thereafter, many of the hospital personnel began to feel that they were objects of a spy system. They would receive what they believed to be "fake" telephoned requests to recommend doctors, the result being that a disagreeable atmosphere became noticeable in the hospital.

## *Is a Closed Staff the Answer?*

How can these problems be solved? To close the hospital to all but a small, well chosen staff is one way. The members of the staff may be trusted to have necessary consultations with outside physicians. But at present this plan does not seem feasible except for a few institutions, such as certain university hospitals. In some ways it would be unfortunate if this plan were widely adopted. Especially to be considered is the possible injury that would result to many good doctors who might lack the personal influence necessary to secure desirable staff appointments.

Another plan, satisfactory in the mind of many, is for the hospital to adopt a positive rule that patients may not change doctors while they are in the institution. This refutes the criticism that the hospital favors certain doctors. If to this rule is added an injunction on all employees against recommending any doctor, there will be, theoretically, nearly water-tight protection against such criticism. However, a nurse may maintain a dis-

\*An address given at the sixth biennial meeting of the California, Arizona and Nevada Conference of the Catholic Hospital Association, San Francisco.



crete silence with her patients, but when off duty she has an inalienable right to answer a friend's inquiries about doctors.

The following example is offered as proof that even the simple rule forbidding patients to change doctors while in the hospital is not an infallible remedy: A patient, believing he has a trivial malady, calls the near-by Doctor A, who orders him to go to a hospital for observation and the next day announces that a serious operation is necessary. The patient had no thought of trusting himself as far as this to Doctor A and desires to have Doctor B. Under the rule he must either retain Doctor A in charge of his case, with Doctor B as consultant, a procedure that is unsatisfactory in principle and an unwarranted expense, or he must move to another hospital, which may be not only inconvenient but also dangerous. As a result, he arrives at the conclusion that he is being victimized.

#### *How the Superintendent Can Help*

After all, there is no doubt that objections could be raised against any inflexible rule that could be devised to solve the professional relations problem of the hospital. The matter is one of good will, good sense and tact, rather than of ironclad rule. But there should be certain guiding principles in the mind of the management. First should be the conception of the average hospital as a servant of the public at large, charged primarily with the responsibility of giving the best possible service to the sick. If it fails to make ends meet financially it will fail ultimately to perform this service. Such a failure is the only legitimate reason for trying to attract patronage and make the institution "pay."

Secondly, but distinctly secondary to the welfare of the patients should be consideration for the interests and the feelings of the doctors and nurses. The superintendent should cultivate an attitude of friendliness toward all right thinking people and should be above the reproach of favoritism. He will then be able to train his subordinates in habits of discretion and tact in conversation, to dissuade his resident physician from stealing cases from Doctor X, and to talk frankly with the honest doctor of little skill and show him how to obtain consultation and assistance that will benefit him as well as the patient. He should also have the courage willingly to accept the enmity and withdrawal of patronage of the dishonest doctor who will not accept such counsel. The non-medical superintendent has a handicap in this endeavor but not an insuperable one. He can gain much wisdom from the staff meetings and from the clinical, pathologic and autopsy records.

## Providing Treatment for Ill Hospital Employees

Many hospitals have some difficulty in providing suitable substitute employees when members of the regular hospital staff become ill. Several hospital superintendents have arranged for a dispensary hour at which time ailing employees may report for examination and treatment. A member of the intern staff or a paid resident physician is usually assigned to this work. It is sometimes difficult, however, when patients are ordered off duty without the knowledge of their departmental heads. Often the first information the head of the department receives is to the effect that one of his workers has been ordered to a bed in a hospital ward.

It is a good rule to require an ailing employee to report first to his immediate superior. In this way, this officer is notified of the probability of a more or less prolonged absence of the employee from work and is prepared. The departmental head sends the employee to the proper physician or notifies him of the sick call time for the personnel. After examination has been made by the physician, a report should be submitted to the departmental head. The employee, unless he is in immediate need of hospitalization, awaits orders from his superior. Sometimes his illness is not so serious but that a few hours or days may intervene before he actually ceases work. When this can be done, the department head has time to provide for carrying on the duties of the ailing employee before he is hospitalized.

Whether or not an employee should be paid for his time off duty is not germane to this discussion but it may be said that institutions frequently allow a certain number of days sick leave during the year with pay. It has been found to be a wise plan to furnish hospital care to ailing employees when possible, since their stay away from duty is likely to be shortened by such care and the superintendent can be constantly informed as to the progress of the patient's illness. Employees should not be permitted to remain in their quarters when ill nor should self-dosage and the purchase of drugs outside the hospital be encouraged. Careful physical examination before engaging new employees is to be recommended. A prompt report of illness among the members of the hospital's personnel tends to lessen the number of days absence for sickness in this type of worker.

## Citizens of Gheel, Belgium, Receive Insane Into Their Homes

There are 3,000 insane persons in Belgium who are not cared for in institutions. Instead they are placed in homes of residents of the town of Gheel, where they are given good care and are made as happy as possible, according to the *Nursing Mirror and Midwives' Journal*. Gheel has cared for a colony of insane since the sixth century. These 3,000 patients are distributed one or two to a family through the homes of the 18,000 inhabitants.

"The patients are nursed by the villagers for the love of God," the article says, "a small sum of money being paid for their maintenance. The medical director chooses the family to which he thinks they are most suited.

"Acute and dangerous cases are of course not admitted to the colony. As it is, each doctor has 600 patients on whom he calls once a month, and each visiting nurse inspects 180 homes every fifteen days."





## A Venture in Hospital Management and How It Has Succeeded

By ROWENA H. RAYMOND, R. N.

Superintendent, Lawrence Hospital, Bronxville, N. Y.

**I**N FORMER years when caring for the sick in hospitals was not so scientifically planned as it is to-day, such hospitals consisted mainly of wards, rooms for private patients, operating rooms and a dietary department. Little thought was given to the housing of the working staff, although it was recognized from an economic standpoint that these workers should live on the premises.

When nurses' training schools came into existence, living conditions for the nursing group were improved by the hospitals that supported them. These changes, however, came about slowly. Even yet there may be found hospitals that have no separate residences for their nurses or, for that matter, any adequate living quarters. In the past this was not unusual in hospitals even of a high type, due to the misunderstanding of conditions by the community.

The Lawrence Hospital was one of these. Built and endowed by William Van Duzer Lawrence, a

leading citizen of Bronxville, N. Y., it aimed to uphold only the highest hospital standards. This hospital, of the colonial manor type, consisted originally of one building which was planned to provide for fifty patients. The community at that time was small and since the idea of hospital service was somewhat new, the patients who sought admission were easily cared for. Sufficient room was left to accommodate the nursing force comfortably. Thus the nurses were housed in the hospital proper, according to the custom then prevalent.

As the population of the village increased and as the hospital became more widely known, it became necessary to provide more beds to care for the ever increasing number of patients. A large wing was built. This not only doubled the bed capacity but also provided for such special departments as the x-ray, the pathological laboratories and the clinics that were necessary in order to keep pace with hospital advancement.

Still no provision was made for a separate home for the workers. Instead, apartments in the immediate neighborhood were leased to house the increased nursing staff. This makeshift of course was not a happy one. Single rooms could not be provided without a great outlay of funds and, as suitable house mothers were difficult to find and to keep, discipline was not easily maintained. Dissatisfaction was general, and the consequent turnover in this department became a question of moment to the managers.

#### *How Funds Were Obtained*

Despite this handicap, however, the hospital census grew apace and the demand for private rooms became insistent. Then it was that the board of governors, impressed by the situation, considered with favor the solution offered by the superintendent—that a residence for the nurses be built, thus releasing for service to private patients the section they occupied.

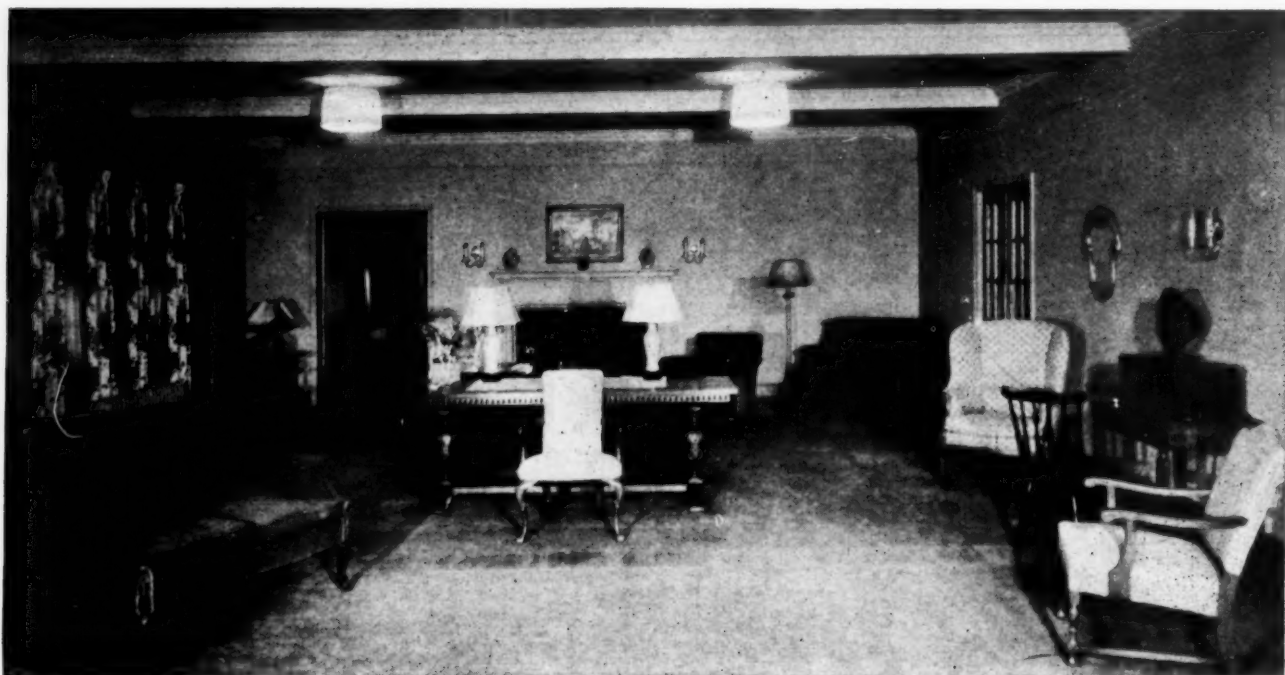
The community was fortunate in having a group of charitable, civic minded men and women who were interested in the hospital, and it was to this group, the community welfare association, that the appeal was made. The associa-

institution made a substantial donation. Soon more than a third of the sum required was forthcoming.

The Lawrence Hospital stands in what is now a semibusiness part of the town, with handsome apartments and small shops in the immediate vicinity. The grounds cover about a city square, and one part of this is a beautiful woodland. In an attractive corner of this section, which has a delightful outlook on the Bronx River and Parkway, it was decided to build the nurses' home.

The site available was in part on sloping ground, one side of which adjoined the street level. This factor led the committee to consider with favor the proposition made by Mr. Lawrence that an apartment block be erected with the lower or street floor given over to small select shops, and with the upper floors used for the required residential purposes. The plan as adopted provides a living section something in the style of a club house. It is modern in all of its details.

The main entrance to the residence is approached from the street by porticoed stone steps, in keeping with the colonial architecture of the building. Adjacent to this entrance lie the tennis



*The nurses' lounge, with its generous fireplace and attractive furnishings, is a pleasant recreation spot.*

tion appointed a committee which made several rounds of inspection with the superintendent and was convinced that help was needed immediately.

A campaign was immediately started to obtain the necessary funds to build a nurses' residence. Prominent citizens, many of them former patients in the hospital, helped. The founder of the

grounds. A rustic bridge spanning a ravine leads to the hospital terrace.

On the main floor of the home a wide foyer gives access to a spacious lounge where a generous fireplace and artistic furnishings, lighting fixtures and lamps make a pleasing setting. Here also stand a concert grand piano and a radio. The

library, well supplied with current literature, opens off this room at the rear. On the opposite side of the foyer are the reception rooms, the post office and the telephone booths, while on the corridor leading to the hospital are closets for umbrellas, rubbers and storm coats. On the main floor the suites consist of bedroom, sitting room and bath, providing dignified quarters for

tures of the home. The room is two stories high and is fitted for basket ball, volley ball, indoor tennis and gymnastics. A billiard table and a ping pong set provide other exercise and amusement. A balcony, which is reached from the third floor, is furnished with comfortable chairs, a piano and a loud speaker extension from the radio. When the nurses give parties or other en-



*This exterior view of the nurses' home of Lawrence Hospital shows the shops on the ground floor.*

the supervising officials. A similar suite is on each of the other floors.

The single rooms are ample in size, attractive in appearance and well supplied with closet space. Besides the usual furniture, an easy-chair, footstool and writing desk as well as a stationary washbowl are part of the equipment. A different color scheme is used on each floor and the gay colored chintzes at the windows and on the tables, with the harmonizing bedspreads, make each unit bright and homey. On each of the upper floors, placed conveniently, is a bathroom with both tub and showers. Each floor has also a "kimono" room, furnished with a card table set, easy-chairs, a settee and a floor lamp. A Chinese motif is used to good effect in the decoration of these cozy rooms.

A diet kitchen, fully equipped, provides each floor with a feature most acceptable to the weary nurse who wishes to "sleep in" on her day off, or to those who find intimate and informal supper parties enjoyable after a trying day. Indeed, the house throughout is furnished tastefully, quietly and comfortably.

On the second floor of the apartment, a large recreation hall supplies one of the unique fea-

tertainments, this balcony is used for the review stand or as an orchestra stall. The diet kitchen of this floor opens off this suite, which makes convenient the serving of refreshments. The corridor leading to this room opens on an outdoor balcony which looks out over the woodland. The balcony, with its colorful tiled floor and its restful furniture, is an inviting spot.

#### *Night Nurses Are Provided For*

The entire top floor of the building serves as a "quiet zone" for the night nurses. This is an innovation that is greatly appreciated. In the basement is a dressing room for "specials," a laundry and the necessary trunk rooms and store-rooms. The elevator shaft in the center of the building runs through the five stories to the roof.

At the present time, Lawrence Hospital does not have a training school for nurses. If such a movement should be considered in the future, however, the entire block could easily be made available for school purposes, with the required laboratories, lecture rooms and classrooms. This would mean, of course, that the shops would have to be eliminated.

This apartment or clubhouse type of nurses'



home is, we understand, an innovation in hospital management. The venture has proved to be worth while. Where dissatisfaction formerly reigned, contentment now prevails. The turnover has lessened materially and, although the board of governors is not a mercenary group, it finds the revenue from the rentals acceptable. There is every evidence that the arrangement will work with satisfaction to all.

The financial management of this project may interest others who wish to provide for their nursing staff a suitable home with all modern equipment and comforts, but who are unable to secure in one move sufficient funds to cover the entire cost of such an undertaking. In this instance the plans called for an expenditure of \$285,300, to which the community campaign fund contributed \$117,000. The hospital was left to carry \$150,000 on mortgage. It is here that the rentals from the shops, approximately \$16,000 annually, come to our assistance, since this revenue more than covers the interest on the mortgages. The community welfare association plans to pay \$10,000 a year until the debt is cleared. A payment covering one year has already been made.

The home has already benefited by a legacy of \$75,000 from the founder, Mr. Lawrence, who was interested in promoting the plan, and we have every reason to believe that still other benefactors will add to the endowment fund.

## What Is Community's Responsibility Toward Its Hospitals?

How far is the community responsible for the financial support of its hospitals?

In answer to this question, J. J. Weber, superintendent, Vassar Brothers' Hospital, Poughkeepsie, N. Y., in a paper given at the American Hospital Association meeting in Atlantic City, first explains the fourfold purpose of the hospital—the care of patients, the teaching of doctors, nurses and technicians, the sponsoring of research into the manifestations of disease, their causes and cures, and finally the carrying on of preventive health work.

To quote from Mr. Weber's paper: "In view of this fact, it is easy to see how largely the hospital serves or is prepared to serve the entire group of citizens in a community. Because of this the hospital should have the financial support of the citizens in its work. The responsibility of helping the hospital to fulfill its fourfold function rests upon the shoulders of the citizens to any one of whom the hospital may at any time mean the difference between anxiety and reassurance, between a permanently crippled condition and a normal condition, even between life and death.

"The cost of hospital service may be divided into clear cut classes—personal service costs and community service costs. In the practical management and financing of hospitals under present conditions, this classification is not

always considered, but it should be used as a basis for establishing a sound financial policy. Until this classification is definitely taken into consideration and acted upon, the present unsatisfactory condition will continue. Hospitals will have burdensome interest charges and deficits, and patients will continue to complain of excessive charges caused by the hospitals' attempt to retrieve some of their losses by saddling the patients with costs properly payable by the community at large. Once the responsibility is clearly recognized and definitely assumed, different communities will doubtless find different ways of meeting it."

## Whom Does the Problem of Hospital Care Actually Concern?

"It is commonplace to say that the problem of hospital care concerns only the great middle economic class," Dr. F. A. Kiehle, chairman, department of ophthalmology, University of Oregon Medical School, told members of the Western Hospital Association at their meeting in Portland, Ore.

"It is striking to read that of the entire number of wage earners in the United States, six million earn less than \$1,000. One million, or only 2 per cent of the adult working population, have incomes of over \$5,000 while eighteen million, or 35 per cent, representing the largest class, have incomes of from \$1,500 to \$2,000. In this class a conservative budget might appropriate \$60 for sickness, but how far would this go in hospital charges in a pneumonia illness or a mastoidectomy, not to mention the doctor's fee?

"Yet, while we are sympathizing with this class, we recall that one out of every seven individuals—not wage earners only—owns an automobile. Some way is found to finance the auto. Probably every family with a car has also a radio. Now both radios and autos are, in general, luxuries. Why not find a way to finance the family hospital charge, which is not a luxury? It seems to me that we have come to the point in our modern life where first consideration is given luxuries, and people resent expenditures for necessities. Luxuries have come to be regarded as necessities, and necessities as nuisances."

## Insurance Program Planned for Milwaukee Nurses

The announcement of the adoption of a group insurance program providing life insurance and sick and accident benefits for employees of the Visiting Nurse Service of Milwaukee has been made by Erna Kowalke, director of the service, states a recent issue of *Hospital Topics and Buyer*.

Under the contract, which is being underwritten by the Metropolitan Life Insurance Company, general employees receive \$1,000 life insurance each, together with sick and nonoccupational accident benefits of \$15 a week. The weekly payments will be made when an employee cannot work because of sickness from any cause or injury received while on duty. If an employee should suffer total and permanent disability before the age of sixty years, the full amount of the life insurance will be paid in monthly installments with interest.

# An Accounting System That Provides Accurate Budgetary Control\*

By ALBERT W. BUCK, Ph.D.

Superintendent, and

ROBERT JORDAN, Ph.D.

Assistant Superintendent, New Haven Hospital, New Haven, Conn.

IN THIS presentation of a simple method of periodically recording the relationship between a hospital's budget and its actual income and expense, no claim is made for the value of such a record as a panacea for all financial ills. It is not assumed that by its use one may either increase the revenue or decrease the operating expense of an institution. It is not a David to slay Goliath—the annual deficit. It is hoped, however, that this method may be of interest and value to those who wish to establish a more accurate control of their financial department.

This system was originated to control the annual expenditure of \$1,000,000 by the General Hospital Society of Connecticut which operates the New Haven Hospital, the New Haven Dispensary and the William Wirt Winchester Hospital. When the system was inaugurated, studies were made of the accounting methods employed in several of the larger teaching institutions of the country. From the information obtained a trial system was evolved which, in our opinion, incorporated the best features of budgetary control. This we applied to our local situation.

## *Method Is Flexible*

While the system was being put in use, we made several modifications and additions but always kept in mind the fact that we desired the maximum of information with a minimum of accounting. We feel that this has been accomplished in considerable measure and that, with the expenditure of a few hours of an accountant's time each month, we are supplied with a detailed picture of our operating expense and income, in comparison with the budget allowances. We are presenting this method because we have found it particularly valuable and because as far as we know, the form in which our record is kept and the method of maintaining it are not in use elsewhere. It may be adapted to meet widely varying situations—either in individual institutions as a whole or in

such departments as present financial problems. It may be used not only for financial but also for commodity control in wards, supply rooms and other hospital departments.

The skeleton of this system is the budget. It is obviously impossible in a paper of this length to discuss the intricacies of budget making. It is necessary, however, not to lose sight of the fact that while we pass over the budget as of little importance, without an accurately estimated and carefully drawn budget the system described would be of little value.

## *Classifying the Hospital's Accounts*

An administrator cannot successfully draw up a budget for the operation of an institution until he has had several years' experience in handling its accounts. He must have time to study the demands made upon the funds as well as the sources of income in order to familiarize himself with the details peculiar to that institution—an argument for continuous tenure of office, if for nothing else. It is only after this experience has been obtained that he sees the full value of budgetary control.

Our experience with one of the institutions under our supervision illustrates this point. During the first two years of operation we had so little information based on past performance that our closing figures for the year demonstrated that our budget was little more than a shot in the dark. Our control has enabled us, however, to correct our early errors in judgment and we now have as accurate figures for this institution as for the institution that has been in operation for more than a century.

Both income and expense must be classified in such detail as to prevent the grouping of dissimilar items under the same heading. Accounts must be classified in such a way that there will be a definite place for each item of receipt or expenditure. The same classification of accounts used in recording the financial activities of the institution must be employed in both the budget and the

\*Presented at the eighth annual meeting of the New England Hospital Association, Boston, October 22 and 23, 1929.

	X	Y	1	2	3	4	9	10	11	12
			Jan.	Feb.	1 <sup>st</sup> Quarter Mar.	Apr.	3 Quarters Sept.	Oct.	Nov.	1 Year Dec.
A	Subsistence —Total	Act.	1350 <sup>00</sup>	1500 <sup>00</sup>	1300 <sup>00</sup>					
		Ac.	1350 <sup>00</sup>	<u>2850<sup>00</sup></u>	4150 <sup>00</sup>					
		B.C.	1400 <sup>00</sup>	2800 <sup>00</sup>	4200 <sup>00</sup>	5600 <sup>00</sup>	12,600 <sup>00</sup>	14,000 <sup>00</sup>	15,400 <sup>00</sup>	16,800 <sup>00</sup>
B	Details omitted for { Salaries & Wages Main Kitchen Vacation Relief " Outside Living Allowance Salaries & Wages Dining Room Vacation Relief " Supplies & Expenses	Act.	xxx <sup>00</sup>	xxx <sup>00</sup>	xxx <sup>00</sup>					
		Ac.	xxx <sup>00</sup>	xxx <sup>00</sup>	xxx <sup>00</sup>					
		B.C.	xxx <sup>00</sup>	xxx <sup>00</sup>	xxx <sup>00</sup>	xxx <sup>00</sup>	Total Budget for Items not shown separately } 2,400 <sup>00</sup>			
C	—Foodstuffs	Ad.	1150 <sup>00</sup>	1300 <sup>00</sup>	1100 <sup>00</sup>					
		Ac.	1150 <sup>00</sup>	<u>2450<sup>00</sup></u>	3550 <sup>00</sup>					
		B.C.	1200 <sup>00</sup>	2400 <sup>00</sup>	3600 <sup>00</sup>	4800 <sup>00</sup>	10,800 <sup>00</sup>	12,000 <sup>00</sup>	13,200 <sup>00</sup>	14,400 <sup>00</sup>
D	Donations	Act.	900 <sup>00</sup>	900 <sup>00</sup>	1300 <sup>00</sup>					
		Ac.	<u>900<sup>00</sup></u>	<u>1800<sup>00</sup></u>	3100 <sup>00</sup>					
		B.C.	1,000 <sup>00</sup>	2,000 <sup>00</sup>	3,000 <sup>00</sup>	4,000 <sup>00</sup>	9,000 <sup>00</sup>	10,000 <sup>00</sup>	11,000 <sup>00</sup>	12,000 <sup>00</sup>
E	Total Income	Act.	5500 <sup>00</sup>	6400 <sup>00</sup>	7000 <sup>00</sup>					
		Ac.	<u>5500<sup>00</sup></u>	<u>11900<sup>00</sup></u>	18,900 <sup>00</sup>					
		B.C.	6000 <sup>00</sup>	12,000 <sup>00</sup>	18,000 <sup>00</sup>	24,000 <sup>00</sup>	54,000 <sup>00</sup>	60,000 <sup>00</sup>	66,000 <sup>00</sup>	72,000 <sup>00</sup>
F	Total Operating Expense	Act.	6500 <sup>00</sup>	7800 <sup>00</sup>	6000 <sup>00</sup>					
		Ac.	6500 <sup>00</sup>	<u>14300<sup>00</sup></u>	20,300 <sup>00</sup>					
		B.C.	7000 <sup>00</sup>	14,000 <sup>00</sup>	21,000 <sup>00</sup>	28,000 <sup>00</sup>	63,000 <sup>00</sup>	70,000 <sup>00</sup>	77,000 <sup>00</sup>	84,000 <sup>00</sup>
G	Deficit	Ad.	1000 <sup>00</sup>	1400 <sup>00</sup>	+1000 <sup>00</sup>					
		Ac.	1000 <sup>00</sup>	<u>2400<sup>00</sup></u>	1400 <sup>00</sup>					
		B.C.	1000 <sup>00</sup>	2,000 <sup>00</sup>	3,000 <sup>00</sup>	4,000 <sup>00</sup>	9,000 <sup>00</sup>	10,000 <sup>00</sup>	11,000 <sup>00</sup>	12,000 <sup>00</sup>

Above is shown a sample budget control sheet. The upper portion shows part of an expense sheet; the middle part, an income sheet; the lower part, profit and loss summary; the vertical broken lines, omission of four months' record, and the figures with wavy underlines, those entered in red.

budgetary control. It is obvious that no two institutions will employ the same classification. This, however, in no way affects the general system since, as we have pointed out, it permits limitless expansion or contraction.

Our budget control is kept in a stock loose leaf form measuring approximately 11 by 14 inches which is ruled with a three-inch column at the left (X)<sup>1</sup> in which are entered the captions of the classification of accounts. To the right of this are smaller columns in which the monthly data are recorded (1-12). Each sheet is of sufficient width to record the figures for six months.

When a budget has once been established for any particular fiscal year, each item of income and of expense is divided by twelve because our hospitals require monthly statements. This monthly

budget figure is entered in the second column to the right of each caption of the classification of accounts on the page just described (1). Two-twelfths of the annual budget figure is entered in the third column to the right (2) and three-twelfths in the fourth column, which is also the quarterly budget figure (3). This method is continued until in the thirteenth column we have the annual budget allowances for each item (12). It is obvious that in Column 6 would be given the figures for a half year and in Column 9 are given those for three-quarters of the year. The arrangement we are using at present provides a column after the sixth month for a record of the second quarter and one after the ninth month for a record of the third quarter. These are used only for comparison with records made before this system was inaugurated and will in time be discarded.

Opposite each caption of the classification of

<sup>1</sup> The numbers and letters in parentheses refer to those shown at the top and left side of the accompanying illustration and serve to indicate the portions of the sheet described in the text.



accounts are three horizontal rulings. The figures just described are inserted in the lowest of these and marked B. C. (Y), meaning budget cumulative allowance; that is, the figure in this line under any monthly caption found at the top of the vertical columns represents the total budget allowance from the beginning of the fiscal year through the month specified.

#### *How Ledger Is Kept*

In the upper of the three horizontal rulings found opposite each caption and in the first column to the right is entered the actual amount of income or expense for the first month. This horizontal space is labeled "Act" for actual (Y). The same figure is entered in the middle horizontal space and labeled "A. C." for actual cumulative income or expense (Y). Obviously, for the first month of the fiscal year the "actual" and the "actual cumulative" figures are the same.

We now have in the first column of figures to the right of each caption three figures (1): the upper, the actual expenditure or income for the month; the middle, the total for the fiscal year to date, and the lower, the budget allowance for the fiscal year to date. On the income side of the control the actual cumulative income is entered in red if it is smaller than the budget cumulative income (D, 1). It is entered in black if it is equal to or greater than the budget cumulative income. On the expense side of the control, the actual cumulative expense is entered in red if it is greater than the budget cumulative expense and in black if it is equal to or smaller than the budget cumulative expense (A, 1). This leaves us with a record of one month's performance.

Continuing with the second month (2), we record in the upper horizontal ruling the actual income or expense. This figure is added to the actual cumulative income or expense (the figure in the second horizontal space) of the previous month (1) and the sum entered in the middle horizontal space of the second month (2). As for the previous month this figure, if income, is recorded in red when it is less than the budget cumulative income (D, 2) and in black when it is greater; if expense, it is entered in red if it is greater than the budget cumulative expense (A, 2) and in black if equal or less.

This method is continued for each of the months as monthly figures are available.

The value of the color scheme in this system is that the administrator, by glancing at a page, can see immediately the danger spots indicated in red: in the case of income, a falling off from any particular source, and in the case of expense, an excess over the amount allotted to that item.

The system is obviously of greater value in controlling expense than in controlling income, for many of the sources of income of a hospital cannot be controlled. It is one thing to require the head of a department to limit his expense for a particular period or to curtail his supplies until the department budget allowance has accumulated and another thing to control the many factors such as incidence of illness, selection of hospital, type of accommodation, requirement for special medicines or treatments, and other items well known to all who have had experience in hospital administration.

One of the most valuable features of the system is its control of profit and loss. The estimated annual income as compared with the estimated annual expense is recorded monthly. At the end of each month's activities, the actual gain or loss is compared with the budget estimate. If the danger sign of red, usually omnipresent, appears it is possible to determine by inspection of two captions whether the fault is due to the income being less than was anticipated or to the expenses being more than was estimated, or both. If, for example, the income is low (E, 1), an inspection of the subtotals makes it possible to determine whether the loss was due to income from private rooms, wards, special charges such as x-ray and physical therapy work or to low interest on invested funds.

If the expense is excessive (F, 2), reference to subtotals will determine which department is culpable. With our classification of accounts, for example, we can immediately tell by inspection of subtotals whether the excessive expenditure was in administration, professional services, general services or corporation expenses. If the general services are at fault we inspect the department totals under this heading. We may find the total subsistence expense excessive (A, 2), and an inspection of the individual items making up the cost of subsistence shows that expenditures for foodstuffs were above the estimate (C, 2). This is as far as our budget control carries us. If more detail is required we have access to the monthly statement of food cost.

#### *Advantages of System*

We have described only a small part of what we consider a satisfactory system of budget control. It gives us an adequate picture of our financial standing at the end of each month. The upper of the three figures opposite each caption gives a monthly financial statement on a standard form which may be compared with records of previous years. It saves the preparation of special monthly reports which are difficult to compare without the handling of many bulky folders. The compar-

ison of the middle and lower figures opposite each caption gives us our budget control.

It is, of course, possible to use this system not only for monthly but for weekly or even daily records.

We feel that this system has so many advantages that we propose to continue its use, although modifications will be made in order to meet the requirements of our rapidly growing plant.

The acid test of any system of this sort is its accurate portrayal of the details of the financial standing of an institution. Standard methods of industry are being required in the administration of charitable institutions, and boards of directors are made up of men who represent the best business interests of the country. Charity consists not only of the dispensing of funds or free care but of getting the greatest possible value received for the money expended.

In discussing some of our problems with an authority on finance, we were told that "If accounts do not give a satisfactory picture of your business, it is much cheaper and equally satisfactory to use two spindles, one for the bills paid and the other for the checks received."

## The Development of the General Hospital in Sweden

The term "hospital" does not mean the same in Sweden that it does in other countries. There it means an institution for the treatment of mental diseases.

The general hospitals in Sweden are called *lasarett*, a name that had its beginning when the first general hospital service in that country was started by the knights of the Seraphim order and named by them, Lazareth, after Lazarus, the Biblical character. The hospital, which came to be known as *Serafimerlasarettet*, was established at Stockholm in 1752.

According to a study of the official hospital organization in Sweden prepared by the state medical board for the 1929 International Hospital Congress, in the very early stages of hospital development the state authorities used a regulating hand, feeling that it was the business of the community at large to care for the sick in the country. By far the greater number of hospitals in Sweden, therefore, whether for the treatment of mental or somatic conditions, have been built by the state, county councils or communities. These authorities are ultimately responsible for the running expenses of these institutions. A census taken in 1927 showed that 46,625 beds belonged to official hospital institutions, while private hospitals had accommodations for only 3,303 patients.

Originally intended for the care of persons of limited means, the hospitals have during the last decades provided treatment for patients without regard to their financial standing. To this end, general hospitals contain, besides general wards, departments of private and semiprivate rooms. Similar accommodations are also to be found in some mental hospitals and sanatoriums. Be-

cause the contributions necessary to run the hospitals come from taxes from the general public, the personal expenses for treatment in general wards are exceedingly low, frequently not covering more than 20 or 25 per cent of the running expenses.

From 3.7 beds in general and mental hospitals per 1,000 population in 1907, this number had grown to 7.1 in twenty years.

## Illinois Plans to Combat Mental Disease Through Education

"In the care of the state's mental unfortunates, Illinois has made wonderful progress," writes Governor Louis I. Emmerson in an article in the *United States Daily*. He continues: "The padded cell and the strait-jacket are gone. Occupational therapy has taken their places. Custodial care in the state institutions is pleasant and sympathetic.

"And yet—based on statistics for the past fifteen years—we are waging a losing battle against mental disease and criminal tendencies.

"Insanity has too long been looked on as a disgrace. Its victims have been locked in institutions and left to die. Such unfortunates have been mentioned only in whispers in the family circle. We propose to view insanity purely as a disease and we have been assured that the large medical schools will emphasize the necessity for study of mental afflictions.

"Illinois, Chicago, Northwestern and Loyola universities have agreed to join forces with the state in a great drive against mental diseases by influencing medical students to take up the study of psychiatry. In numbers we find strength, and the spirit of helplessness and hopelessness which has in the past characterized our conception of treatment for the insane, will give way to a reasonable optimism when our colleges make good their promises to give us a great corps of men and women, who, having specialized in the study of mental diseases, may be expected to advance our knowledge of prevention and cure."

## The Value of the "Hospital Council" Meeting

An organization that Dr. Howard H. Johnson, medical director, St. Luke's Hospital, San Francisco, considers essential to the efficient functioning of the hospital is what he calls the "hospital council," made up of the heads of the various departments—the business office, the training school, the laboratory, the x-ray, the house-keeping, the dietary, the purchasing and the engineering. In the small hospitals many of these departments are necessarily combined in and presided over by one individual, Doctor Johnson emphasized in a speech made at the meeting of the Western Hospital Association, Portland, Ore.

The hospital council should meet at least once a week, at a definite hour, and attendance should be made the rule. The council is presided over by the administrative officer who brings to it matters for discussion and study by the department heads. In this way, difficulties may be handled and settled satisfactorily for all. Such meetings are conducive to temperance and to cooperation, and make it possible for friction or unfortunate incidents to be fully, freely and sympathetically discussed.

# Music as a Medicine and a Tonic in Restoring Health

By ISA MAUDE ILSÉN

New York City

IN CONTEMPLATING the possible practical applicability of music in hospitals of the future, one must remember that the concept of music itself will probably undergo great expansion owing to persevering investigators in all parts of the world who are bringing to light new themes and methods.

American Indian music affords a wealth of raw material for modern composers. A study of primitive African music has made its presence felt in the ubiquitous jazz of to-day, and one hopes for a more serious treatment of the African contribution to music lore. In some future period we may arrive at a wider knowledge of the music of the classic peoples, that music to which Plato, Terpander and mythologists ascribed such miraculous powers. The present excavations of Herculaneum conducted by Benito Mussolini may yield several lost books on musical theory and practice written by Theophrastus and Aristozenus. Such informing material might enable the present generation to reproduce once more the miracles of Orpheus and Amphion.

## *Field of Research Is Fertile*

The untiring efforts of Biblical archeologists should throw new light on the music of ancient Israel. It would indeed be interesting to know why David in his first attempt at musicotherapy succeeded in calming and soothing the king "until Saul was refreshed and well" while the harp solos rendered at the second attempt incited Saul to frenzy. Could it be that the words, rhythm, tone color, composition and keys were improperly arranged?

And the field of research is not exhausted when one has utilized the resources of primitive music and penetrated the secrets of classical melodies. The complexities of Oriental music still await interpretation before they can be incorporated into the universal music of the future, the cosmopolitan or world music that is to charm coming generations. The Arabic, Chinese, Malay, Siamese and Hindu races offer contributions. All of these races, particularly the Chinese and

Hindu, possess elaborate systems of music which differ radically from Occidental music. But who shall say that such systems are false, or that we may not profit by studying them? The elaborate correlation of Hindu sagas with their appropriate emotions is a case in point. Hindu musicians make a science of creating emotional tone pictures. Western composers may learn from their technique, and medical psychologists may benefit by the experimental investigations of the psychological influences of melodies that are now in progress.

## *What the Future Promises*

Connected with the development of a richer and more varied art of music will come a more practical attitude toward music. We shall realize that music is not a mere luxury, or an esoteric art confined to a few connoisseurs, artists and technicians. Music will become a necessity, a matter of mental hygiene of the future. The "music supply" may come to seem as important an item as the water supply. In such an event we may expect a tremendous increase in the institutional use of music. Hospitals, asylums, kindergartens and schools of every type, as well as factories, prisons and good hotels will begin to exploit the healing, humanizing and energizing influence of music. This in turn will result in the creation of a new professional class of especially trained physicians and nurses and industrial specialists who will control the use of music as a medicine and as a tonic. The creation of a healthy musical environment will itself become an art.

Incidentally, such a class may also contribute to the progress of music along sane lines by laying down standards of what is good or bad music from the standpoint of human welfare. Music may be definitely antisocial or eminently social. It may be productive of effeminacy, brutality or lasciviousness or, on the other hand, it may be creative of that inner beauty and personality in the absence of which external attractiveness is vain and deceptive.

Modifying slightly a statement of Dr. A.



Savill, we may say that it would not be surprising that the trained physician or nurse, able to distinguish good music and bad music by the respective results upon sensitive individuals, could foretell that which would be permanent and that which would be evanescent. Bad music would then pass rapidly into oblivion while good music would persist as a permanent possession of the race. Following upon this, we may expect the development of a new group of musicians who will compose especially in the interest of public health and morale, thus realizing another of Plato's dreams of the "Ideal Republic."

#### *Determining Musical Sensitivity*

The realization of such ideal conditions of musical composition and evaluation is particularly desirable, since too much contemporary music is of an infantile character. One observer has remarked: "Infantile music is both easier to compose and easier to hear than mature music, so the public and the musician find themselves in a natural league in favor of the rawer kinds of music. Thus the song of obvious and commonplace sentiment and the jazz tune of blatant rhythm have universal popularity." But the facile in music as elsewhere is not always favorable to either body or spirit.

Another possibility of the future is the census of musical sensitivity. By means of the new tests devised by Dr. Carl Emil Seashore and his pupils, the musical sensitivity, as well as the probable executive skill of an individual may be readily determined. The subject perception of pitch, intensity, kind, rhythm and capacity for musical association and imagination, as well as his skill in motor coordination which determines performance, can be accurately recorded. In a word, a person's musical profile may be constructed. Already these tests have been used with success in Iowa to determine early talent in children. This is an important step in the conservation of genius which is certainly one of natural resources as much as oil or forest land.

By extending this method of music testing to the whole population, other important purposes might be served. The degree of musical sensitiveness of every individual could be registered, yielding a datum that would be valuable to physicians and nurses in the musical treatment of bodily and mental illness, since it is clear that the type of treatment and the actual music employed will vary with the sensitivity of the patient. Incidentally, a census of the musical sensitivity of the population might disclose regional differences of interest to sociologists, as well as supply data of value to broadcasting stations.

Psychologists and psychophysicists are contributing in still other ways. Psychologists are gradually establishing the existence of certain well defined types of auditors. Not only will the individual sensitivity of auditors be known but also the general type of reaction involved. Certain psychologists have already classified individuals under four categories: objective, where objective aspects of musical elements absorb the individual attention; subjective or psychological, where psychological organic changes are uppermost in "consciousness; associative, characterized by the appearance of memories in connection with the music; the character type, where musical symbolism is dominant. The value of knowing a patient's status with respect to musical reaction is incalculable in cases where music is to be used.

On the other hand, Doctor Seashore, to cite once more one of our most indefatigable and original investigators, says that "Modern phonophotography opens to us an enormous new field for investigation and for the laying of the foundations for the science, the esthetics and the pedagogy of music and speech." It is clear that it will therefore contribute to progress in the therapeutic use of music and aid us in our selection of hospital programs. Doctor Seashore continues: "It offers us a new approach to the psychophysics of the expression of emotion. In the psychophysics which was the making of modern psychology, we controlled the stimulus. In this psychophysics we measure the output. Even the expression of emotion through music or speech may now be measured with fully as high degree of precision and with the same ease that we used to control the stimulus in the psychophysics of sensation."<sup>1</sup>

#### *Utilizing the Tone and Color Relationship*

We may next consider a psychological phenomenon which has attracted much attention in recent years but which has served no practical purpose so far, although efforts at esthetic utilization have not been wanting. The well known fixed relationship between tone and colors or between certain musical selections or even composers and color, a phenomenon known as chromesthesia or color hearing, may finally be utilized in a practical manner. In a typical instance of color hearing, colors were ascribed to the notes of the musical scale. In other cases, colors were ascribed to the vowels of the alphabet, and French symbolists attempted to construct poetry according to this principle. The idea was to suggest color to the auditor and thus equip poetry with the powers of painting. Rem-

<sup>1</sup> Scientific Monthly, May, 1927.

baud's celebrated sonnet was an effort in this direction.

The frequency of colored hearing is considerable, from 12 to 43 per cent of cases being reported. It is obvious that some use should and will be made of the phenomenon. Efforts have already been made to produce a color organ. But the easily observable analogies between the respective series of tones and colors make it reasonable to suppose that some method of translating pleasing combinations of tones into colors and *vice versa* will be found. Dr. George Zehden of Berlin cites the case of a pianist who visualized a certain color in connection with every piece she played, so that eventually her entire repertoire was associated with a definite color scheme. The advantages of such a discovery to the blind and deaf may readily be appreciated. The blind may in this way, so to speak, participate in the pleasures of the eye when they are translated into those of the ear, while melodies to which the deaf cannot respond may be transcribed into colors they can behold and enjoy. In the future, the deaf may in some measure see Beethoven's music as the master probably saw it in his own marvelous mind, although he was afflicted in his later years with absolute deafness.

#### *Creating Music From Light*

Mystics have sometimes spoken of perceiving a beautiful sunset as a burst of melody or a symphony. The dream of the ardent mystic may be realized as cold fact. Sunsets of the Golden West or the aurora borealis of polar climes may yet be translated into musical selections and broadcast by radio to avid listeners in Cuba or in Illinois. The hospital patient or chronic invalid may then enjoy a sunset on the dreariest of winter days. The creation of music from light is a world-old dream. Tradition informs us that more than three thousand years ago in Egypt the giant statue of Memnon emitted wierdly beautiful notes when struck by the first rays of the rising sun. In Dr. Lee de Forest's laboratory there are a number of small spherical incandescent bulbs. From these bulbs may be obtained a succession of musical notes, clear and sweet and of surprising volume, the pitch and timbre of which can be varied almost at will to imitate any musical tone of an orchestra.

A few words must be said about the use of radio music of the future. Shall we be able to broadcast taste, health and much desired musical blessings to those who crave them? Regarding the first point, it is a fact that the musical tastes of the masses are being improved by radio service, which is a great and valuable achievement.

Percy A. Scholes says: "The introduction of broadcasting seems to me to be comparable to the introduction of printing. Less than two hundred years ago amongst the people at large there was literary stagnation; nowadays a man can buy the masterpieces of the world's literature in cheap editions. To some extent the gramophone has already done for music what printing did for literature, but broadcasting will do far more."

#### *A New Vocation for Music*

With respect to the production of health, and especially through treatment of hospital patients by radio music, the method involves grave dangers. The following excerpt from "Speaking of Operations," by James Radly, speaks for him and numbers of others who have voiced and written their longings for a real hospital program:

"As a matter of fact I believe the doctors here mistrust the value of music as a reliever of pain. I was pretty well on my way to recovery before they let me have any of it, and then it was the radio, and I was permitted to hear it with a manner that said, 'You are strong enough now to hear some music.' I think, though, they overestimated my strength, for the jazz things that sometimes came across the air would have required a stronger condition than mine was, to endure without hardship." So it remains for the radio to be equipped not only with a musical critic, but also with a department for the arranging of hospital programs, with a trained director of hospital music to supervise and conduct it, thus creating a new vocation for music.

A census made in 1928 showed that in the United States there were 6,852 hospitals of all types. A dream of the future, a practical feasible dream, is to have every hospital provided with a comprehensive authoritative list of hospital musical selections and supervised by a trained director of hospital music. There should also be a radio installation with a new kind of ear phone. The present ear phones are clumsy and nonsterile. Carefully prepared hospital programs could be broadcast for the patients to which, of course, everybody would be privileged to listen. Often an infirm body that does not require hospitalization is "but a cloak for a sick and weary soul," and the right music will prove most helpful.

As the Arabians centuries ago set aside music rooms in their hospitals, so to-day one should be set aside in every modern hospital. It should be equipped with mechanical instruments such as the phonograph, the reproducing piano and a harp and violin combination, all fitted with electrical devices to carry the "poetry of sound" to any patient in the institution.



It is not at all an incredible thing to look forward to the time when the medical fraternity will write musical prescriptions. The physician, let us say, visits a patient who is suffering from insomnia. After his visit he prescribes as follows:

- 1 well tuned harp
- 1 sweet voiced soprano

No. 7 ("O, Night of Love," from Tales of Hoffmann.)

Sig. — Noct.

\_\_\_\_\_, M.D.

The next morning, if the night nurse reports the prescription has not been entirely satisfactory, he augments the treatment by:

- 1 violin, muted
- 1 contralto voice
- 1 piano (in tune)

No. 10 ("Jocelyn's Lullaby" by Godard.)

Sig. — T.i.d., p.c., et noct.

\_\_\_\_\_, M.D.

When this is considered of sufficient importance to be put into everyday practice, then, and only then will Dr. Egbert Guernsey's almost prophetic words acquire the significance of the actual realization of music in hospital régime under the supervision of a musical director, with physicians and nurses understanding the efficacy of music in sickness. In Doctor Guernsey's day, few persons recognized the value of using music in hospital work, but this generation has come to realize the power of music rightly used. Although the growth of the idea has been phenomenal during the last few years, and many hospitals include organized music in their regimen, the fulfillment of the vision of organized music in every hospital is yet a long way off. When this dream is realized untold good will result.

#### *Music in Future Nurse Training*

Since 1916, the school of nursing and health of the Cincinnati General Hospital, Cincinnati, has been affiliated with the college of medicine, University of Cincinnati, and all student nurses are required to take an elementary course in psychology in the college of liberal arts. If any student wishes to earn the bachelor of science degree in nursing and arts, she is encouraged to take additional psychological courses.

The training school of the future no doubt will provide a course to prepare the nurse in the art of taking music into hospitals and thus add the extra letters, D.H.M. (Director of Hospital Music), to her diploma. Then the patients whom she helps on her errands of helpful mercy will be doubly blessed when she gives them the music that is best for them, temperamentally, physically and nationally.

## A Hospital Business Manager Talks on Salesmen

When Robert B. Witham, business administrator, Children's Hospital, Denver, interviews salesmen he wants to get from them certain facts about the goods they sell. These facts he lists in an article in the *Institutional Jobber* as follows: How the goods are manufactured; the materials used in manufacture; why they are used; the application of the product to the needs of the buyer. Mr. Witham says that in 75 per cent of the cases he finds high pressure the defense mechanism of an inferior salesman.

"I am always anxious and eager for intelligent information and am willing to listen to the man who can tactfully and ably discuss and present his product. If he dispenses with the prepared high pressure sales talk so much the better. When a salesman is offering something new to my experience I want him to be able to tell me the names of other institutions that have used it, how they have used it and with what result.

"No executive tolerates a procrastinator unless he is one himself. I hold the salesman to rigid rules in the matter of appointments. The reason for this is that I have no purchasing agent and my time is more than taken up every day with routine affairs incidental to the business management of the hospital. The salesman is only a detail in my day but is nevertheless an important one.

"I keep a card file of the salesmen who call upon me, with notations upon the worth of the product represented, the type of salesman representing it and the result of his last call."

## The Strategic Position of the Hospital Social Worker

Because the hospital is irrevocably tied up with the progress of public health, because it is more and more taking its place as an aggressive health center, its advancement depends on sound medical and social progress. In promoting this progress, the hospital social worker is in a strategic position, Dr. H. E. Kleinschmidt, supervisor, medical service, National Tuberculosis Association, New York City, points out in a paper appearing in *Hospital Social Service*. Doctor Kleinschmidt gives the following description of the activities of the hospital social worker:

"For the doctor the hospital social worker interprets the social problems of the patient and for the patient she supplies the social treatment necessary to the success of the doctor's therapy. She sees daily the interrelation of social pathology and physical disease. Through her tact, doctors and hospitals learn to understand factors that are not so apparent within the walls of the institution while social and public health workers learn to appreciate something of the technical problems of medical practice. She is the connective tissue binding together and coordinating the highly specialized services of medicine and social welfare. She comes into the old and honored field of medicine unhampered by hoary tradition and with a fresh viewpoint. She serves all these important statesmanship functions in addition to the fine, devoted personal service she renders daily, lightening the load of the distressed and brightening the dark shadows of life."



# What the Cooperation of the Press Means to the State Hospital

By J. ALLEN JACKSON, M.D.

Superintendent, Danville State Hospital, Danville, Pa., and

REED McCARTY

Editor, *Morning News*, and Director, Danville State Hospital Department of Public Information

**I**N LINE with the general trend of the times that there should be a closer relationship between the hospital and the press for the benefit of both the public and the hospital, more than a year ago there was created at the Danville State Hospital, Danville, Pa., a division of hospital information.

This division was made a part of the community service department, which is concerned with the work of the clinics and with the dissemination of knowledge having to do with the prevention, the early recognition and the care of mental illness.

Since success in any venture depends on a well formulated plan, definite objectives and an organization of adequate personnel and maintenance, all of these were provided for in the new division of hospital information. It was planned to make the venture a part of our community activities. A director was selected and a budget provided.

The division was made a part of the community service department; the director, an editor, was appointed; a budget of \$900 was provided. The object was to create a different viewpoint regarding the work of a hospital, its functions and its activities, and to encourage a better understanding of mental illness on the part of the public. The promotion of the program, as is the custom with the work of the departments, was delegated to the chief of the newly created division. The trustees of the hospital and the superintendent have been gratified with the results. It has also been gratifying to receive from the community and the press only commendation, encouragement and appreciation.

## *Releases Made Weekly*

A survey of the field to be covered in the presentation of state hospital information disclosed that a population of nearly two millions was served by sixty newspapers, with a total circulation of 400,000 subscribers. These newspapers ranged from metropolitan dailies to four-page weeklies in towns with a population of less than 1,000.

A study of methods used by large organizations and institutions in presenting their activities to editors for publication indicated that a weekly release to the newspapers would be as much as the hospital, with fairness to editors, could ask them to consider. Releases to the newspapers more than once a week appeared to the director of the department to constitute an imposition upon busy editors, at the same time affording them the temptation to cast the hospital's envelope, unopened, into the wastebasket merely because of its frequent appearance on their desks.

## *The Kind of News That Goes Out*

At the same time, the activities of the hospital are so manifold that there is provided ample material for an article of interest every week. The weekly repetition also provides a cumulative effect, that lends force to the program. Primarily, the most essential phase of the program of public information was to provide articles containing sufficient reader interest to merit publication. Any amount of technical or "elegant" articles could be prepared and issued to the newspapers, but unfortunately editors do not print items merely because their phraseology is excellent or their contents profound. The busy editor must cull the news from the reams of typed and printed matter he receives. The news goes into his paper and the propaganda into his wastebasket. Therefore, from the first, the director of the department issued only news to the editors. There has never at any time been an effort to impose upon journalistic good nature by flowery praise or personal publicity. The events of the institution have been publicized rather than the reputation of an official or the merits of an individual. This has been done at the express request and with the continued approval of those at the head of the institution.

The news matter issued from the department has fallen into three general divisions. They are: first, general events; second, activities of the board of trustees (public servants appointed by the governor); third, information tending to educate the public as to the cause, nature and preven-

tion of mental diseases. Broadly, the aim of the program is to inform the public as to the activities of their mental hospital, and to educate them as to the nature of mental disease. Specifically, the results aimed at in the department were to impress strongly upon the public consciousness that the Danville institution is a hospital for the care and treatment of mentally ill persons, not an asylum for confinement, and that mental ills are preventable and curable, rather than an affliction visited upon a certain number of unfortunates as an act of God.

#### *What the Articles Tell*

As a direct result of this endeavor may be cited the fact that in the year and a half of its operation the director has noticed in newspaper headlines in thirty newspapers the words "mental hospital" more than 500 times and "insane asylum" not once.

Examples of the news articles submitted to the newspapers under the head of general news include such captions as the following: "Christmas Week Will Bring Cheer to 1,800 in Mental Hospital"; "312 Employees of Mental Hospital Care for Patients"; "Extensive Wiring Project Completed at State Hospital"; "Mental Hospital Must Be Run as Up-to-Date Hotel."

Numerous articles were designed to show that mental patients are human individuals enjoying many normal emotions and pleasures, as the following articles typify: "Mental Patients Enjoy Movies"; "Three Fourths of Mental Patients Work for Living"; "Dancing Plays Part in Treatment of Mental Disease"; "Only Small Proportion of Mental Patients Violent." Emphasizing the function of the hospital as an institution for cure are such headlines as the following: "Forty Patients Discharged After Mental Treatment"; "Mental Hospital Shows Thirty Patients Cured"; "Many Children Saved From Insanity at Mental Clinics."

#### *Mental Health Talk Given Monthly*

Of more importance than any of these, however, is the part played by the superintendent in his monthly mental health talk, which, given a "newspaper lead" by the director of the department, carries educational information to the readers of an average of twelve newspapers monthly. Such titles as these indicate the scope of the articles: "Ten Per Cent of Mental Patients Victims of Social Disease"; "Mental Diseases From Liquor Increase 700 Per Cent in Nine Years"; "Says Work Is Best Means to Perfect Mental Health"; "Hospital Head Tells How to Iron Out Mental Kinks."

Has the effort been successful? Fortunately, the results, in terms of newspaper space, are tangible and can be readily summarized here. As to the intangibles—the good that has been accomplished by the information and education carried to thousands of readers, the clarified conception of mental hospital functions, scopes and purposes instilled in the public mind and the consciousness of mental derangements as diseases that can be prevented, intelligently treated and permanently cured—these are results whose value can never be accurately estimated.

In the first year of its operation, the bureau reported the following results: number of columnar inches devoted to hospital publicity, 3,667, or 183 columns, 26 newspaper pages; average number of newspapers in hospital territory using information monthly, 17; highest number of newspapers using information during one month, 30; the number of subjects that had been discussed in newspaper articles, 38.

If a final word may be added to this summary, it is that in all the space thus accorded the hospital and in all the articles thus submitted to the public, there has been the one object of providing to its constituent public information on the hospital as an institution of mercy, rather than praise upon individuals who happen to be connected with it. The response of editors, publishers and the public is an excellent testimonial to their appreciation of the value and worth of the program and their cooperation has aided and encouraged us in our efforts.

#### *Conclusions*

Three points are outstanding in the formulation of the publicity program for the mental hospital. They are:

1. The public press is one of the greatest agencies in combating the ancient prejudices against the mental hospital and in promoting a better understanding of the mentally ill on the part of the public.

2. There should be the closest cooperation between the press and the hospital. Such cooperation should be based on the mutual understanding of definite objectives, the information to be given and its careful preparation to that end.

3. Getting mental hospital information to the public can be most effectively accomplished through a well organized department of hospital information with a qualified director at its head.

The director of the department has been greatly helped in his work by the cooperation of the editors of the public press in the Danville State Hospital district.



# How Teaching Hospitals Can Train Medical Social Workers\*

By GRACE BEALS FERGUSON

George Warren Brown Department of Social Work, Washington University, St. Louis

WHILE it is understood that the student of medical social service comes to the hospital after she has had her basic training in general social work, it is in the medical institution that she learns the procedure of medical social work as a specialized type of activity. She brings with her a knowledge of social problems and possible means for their solution and an understanding of the interrelationship between the individual and his social environment, and she is able to apply these in the treatment of social ills.

What contribution has this person to make to the practice of medicine in hospitals, and what additional training must she have so that she may effectively function in these institutions? Does the teaching hospital have any significant part to play in this training program?

Since 1921 the American Association of Hospital Social Workers has been giving special attention to this problem. As a result of its study and of the experiences of the various training centers, certain facts regarding training in relation to teaching hospitals have been established. It has become evident that such hospitals are particularly fitted to participate in three phases of the teaching plan, first, in giving field practice, second, in providing formal instruction in the medical courses for social workers, and third, in presenting the opportunity to participate in medical social research.

## *Activities of Social Worker*

To show the importance of these three teaching projects as means of equipping the student to carry on the practice of medical social work, let us restate the major activities of the social worker in the hospital as they have been formulated by the committee on functions.

To begin with, there is the process of "making inquiry into the social situation of hospital patients and reporting the findings to the responsible physician." For instance, has a knowledge of the patient's personal history, his family life and relationships, his economic and industrial status

and an interpretation of his social contacts, as secured by the social worker, been of significance to the physician in his understanding of the entire individual and his health problem? It is also important for the physician to know the presence of disturbing factors in the environment of the patient that have any bearing on his illness or that may prevent successful treatment. This leads to the definition of the next step taken by the social worker, "determining, in collaboration with the physician, the factors in the social situation pertinent to the patient's health and stating these as medical social problems or diagnoses."

## *How the Patient Is Helped*

The study of functions has shown that there are three main groups of social factors that appear in hospital practice: (1) social conditions that bear directly on the health of the patient, either inducing susceptibility to ill health, or helping or hindering medical care; (2) social distress caused to others by illness of patients; (3) social problems not having direct cause and effect relation to the health condition, but collateral to it. "It is clear," the study concludes, "that the social factors that come under the first heading are the proper and special concern of the doctor, and therefore of the hospital, and that social work done under hospital auspices will deal largely with such conditions." Ability to recognize and isolate pertinent social factors which vary according to the medical problem, and to express them in terms of "social diagnoses" is accepted as one of the important functions of the medical social worker.

Then comes the process of "setting up in collaboration with the physician a possible goal or best estate for the patient to aim for, given the medical problems and the social situation of the patient, and distinguishing the rôle the social worker is to play in the plan for helping the patient achieve the goal." When the physician determines upon sanatorium care as the best plan for a tuberculous patient whose social history reveals that she is the mother of five small children, that the family income is inadequate and that there is none in the family group capable of help-

\*Read at the thirty-first convention of the American Hospital Association, Atlantic City, N. J., June 17-21, 1929.



ing, it is the social worker's task to undertake the various adjustments necessary before the plan can be carried out. This brings us to the final step, which is "executing the social worker's part in the plan for helping the patient to achieve his best estate."

The statement of the extent of the major activities carries with it the recognition of the close cooperation between the social worker and the physician within the medical institution. Accordingly training for the successful execution of those functions can best be carried out in the same environment. When that institution is a teaching hospital, we have the best possible place in which to train the student. We assume that such a hospital places no limitation on its educational activities and that the instruction of all who come within its doors is taken to be one of its chief responsibilities. To-day, then, we include the medical social worker among those whom the teaching hospital recognizes as its pupils. She becomes another member of that already large group of workers—medical students, nurses, dietitians, occupational therapists and others, who share in work with the patients.

#### *"Field Work" an Asset*

In common with most professional students, the trained social worker must possess certain essentials for successful performance. Educators list these as skill, knowledge and philosophy. While the teaching hospital can help her acquire all three, its outstanding contribution, perhaps, is in providing opportunity for her to acquire the skill in performance or mastery of her methods of work. One of the surest ways in which skill can be developed is through practice. The curriculums of the schools of social work describe this practice as "field work," and it is in furnishing the place for practice that the teaching hospital plays an important rôle in the training of medical social workers.

Dr. William Welch, Baltimore, in stating the need for bedside teaching of medical students, described the ideal type of teaching as that which will "bring the students into intimate prolonged personal contact with the object of study, in this case the living patient, which secures that vital useful knowledge, the possession of which alone is power for good, and the lack of which is helplessness and power for harm." This type of teaching is also ideal for giving medical social workers their field practice. We would add to his description "the study of the living patient and his environment," since the environmental influences must be studied also in order to determine their relationship with the entire health problem.

Primarily, then, field work offers the student the opportunity of developing skill in the performance of the functions of medical social work by carrying them out in practice. It is also the means by which the student tests and applies the facts and theories learned in the classroom and from reading. This application of theoretical knowledge to concrete situations is one of the best ways of making sure that the knowledge has been thoroughly grasped. Lecture and class discussion are not enough.

#### *How Experience Is Obtained*

It is assumed that each teaching hospital has its own medical social service department and that this department shares with the hospital its educational function. The director of such a department in a teaching hospital is usually one who has ability to work with students and whose qualifications for her position are similar to those of the rest of the staff in regard to teaching ability. The student, then, is assigned to this department for her field work experience. There she actually carries on the activities that make up the job of the trained worker, in the same way as the fifth-year medical student or intern, going into the hospital immediately after completing his undergraduate medical work, shares in the work of the experienced physician who is treating the sick.

In addition to carrying on the usual case work activities, the social worker may have the experience of attending the regular ward rounds as a member of the hospital group included in such a procedure. In some hospitals, as at Indiana University Hospital, Indianapolis, for instance, special ward rounds may be conducted for the social workers themselves, and the physician directing them particularly stresses the correlation between the social aspects of the case and the medical problems. The student social worker is under supervision and guidance during the entire time spent in field work, but at the end of the complete training period she should be fully qualified to serve on a social service staff.

#### *Social Worker a Regular Student*

Field work is not apprentice work in the sense that there is any binding agreement on the part of the student to give services in return for instruction received. True, the first medical social workers like the early practitioners of law or medicine were taught by apprenticeship. Now, however, that process is recognized as having so many shortcomings that it has been supplanted by a procedure that is more completely educational. Field work is built into the curriculum of the training school and carries both graduate and

undergraduate credit on the same basis as the regular class work. Like the rest of the course, it is under the direction of the faculty of the school.

The cost to the hospital in providing this type of teaching through its department of social work is mainly the time and effort given by the field guides to that service. It is partially offset by the gain derived from the work of the students when they have progressed far enough to assume more or less responsibility for a limited number of patients. A hospital executive who has had long and close contact with the students in training in the university hospitals over which he was administrator believes "that a teaching hospital recognizes the fact that a high grade student renders a certain amount of service in return for whatever money or effort is expended on her account." She renders that service not only within the hospital but outside, since she definitely helps to establish relationships between the hospital and the community of which she is a part. She is another connecting link serving to bring more closely together the hospital and the community.

#### *Time Spent in Field Work*

The length of time spent by the student in field work varies. It should be sufficient to bring worth while results both to her and to the agency. For undergraduates it may average from one to three days a week throughout the school year. The graduate student is expected to give correspondingly more time to her practice work. When it is possible to do so without conflicting with the classes, she at some time devotes every day for a period of several weeks to field work exclusively, in order to know every aspect of the medical social worker's job. To develop skill in all its processes is the end toward which she works.

In regard to the major activities outlined, it is evident that the social worker in the hospital must have definite medical knowledge, and that without it she is neither able to understand the patient and his problem fully nor to work with the physician intelligently when discussing "the factors in the social situation pertinent to the patient's health," or in "setting up," with him, "the possible goal, for the patient to aim for, given the medical problems and the social situation." Therefore as part of the training for medical social work, courses designed to furnish this medical information have been included in the curriculums of the schools. Here, as in field work, the teaching hospital is the logical source from which to secure this type of instruction.

The basic course in medicine for social workers must necessarily be general in nature, and its

purpose is to present, as if to the layman, the etiology, symptoms, diagnosis, treatment and prevention of the diseases of most frequent incidence and about which the social worker must have accurate scientific knowledge. The teacher who has been accustomed to instructing medical students and student nurses is the one most likely to have an understanding of the problem of introducing the nonmedically trained student to scientific medical subject matter and can best guide her later efforts to expand her knowledge of medicine. In addition to formal class lectures, she may have the opportunity to attend teaching clinics, to observe special demonstrations and in other ways add to her medical background. The social worker who has a large fund of medical knowledge to call upon is the one who is capable of doing intelligent medical social work.

Finally, to skill and knowledge we add that other essential of the trained person without which all work, especially if it deals with human lives, is flat, meaningless and insecure—a philosophy, personal and social. There is no special process by which a philosophy may be evolved, and the student is perhaps unconsciously shaping her philosophy during her entire career. It is evident, however, that her philosophy as well as her skill and knowledge is given depth and meaning if she is able while still a student to participate in or to observe the research function of the teaching hospital.

One of the great medical educators has said, "Unless the spirit of research be in such a hospital and pervade its various staffs, the educational function languishes and the hospital atmosphere is stale." Research and the teaching hospital are almost synonymous. Exposed to this zealous search for new truths and taking part in it, perhaps by way of furnishing social data for the physician, the medical social worker unmistakably benefits by the mental discipline that is involved.

#### *Increased Training Opportunities*

Some of the typical projects suggested by physicians for students to participate in are similar to the study of the environment of patients with rheumatic heart disease in an effort to find any possible relationship between climate, dampness and geographical location and the rheumatic fever attacks. Studies of this sort train the student to guard against attributing too much significance to correlations that may be coincidental rather than casual. Assisting the physician in a research project of a more technical medical nature aids in training the medical social worker to be accurately analytical and honest in drawing conclusions.



It is a means of helping her to maintain an intellectual balance.

It is, then, not by chance alone that six of the nine training centers for medical social work are integral parts of universities that have teaching hospitals connected with their medical schools. All nine of the teaching centers have established relationships with teaching hospitals so that field practice may be carried on in them, and the tendency is for the training in social work to be given as part of the university's educational program. Those nine training centers are at the New York School of Social Work; Western Reserve University, Cleveland; Simmons College School of Social Work, Boston; University of Chicago; National Catholic Service School, Washington, D. C.; University of Minnesota; Indiana University; Tulane University, New Orleans, and Washington University, St. Louis. These schools have developed teaching hospital affiliations largely because they can so adequately give the student opportunity for field practice, instruction in medical subject matter and insight into research in various fields.

### How the Various Countries Provide for Their Sick

How do the various countries rank with regard to the number of beds to be found in their institutions for the treatment of the sick?

Dr. W. H. Mansholt, medical director, General Provincial Municipal and University Hospital, Groningen, The Netherlands, prepared for presentation at the 1929 International Hospital Congress a study of hospitals of European and American countries which gives interesting facts about the hospital situation in those countries. The following statistics are given in the study:

Denmark has 73.8 hospital beds for every 10,000 inhabitants; Norway, 71.5; Sweden, 71; Finland, 38.1; Russia, 13.6; Poland, 23.7; Lithuania, 10.8; Czechoslovakia, 35; Austria, 49.8; Hungary, 36.4; Bulgaria, 14.6; Switzerland, 84; Germany, 80.5; Belgium, 42.5; The Netherlands, 65; France, 25.6; England and Wales, 94.7; Scotland, 78.6; United States, 74.5; Australia, 64.7; Japan, 17.1. These figures include hospitals for the mentally diseased and for the tuberculous.

No figures were available for Estonia, Jugo-Slavia, Luxemburg.

Latvia has ninety hospitals. Roumania has 326 hospitals including seven asylums and four sanatoriums. Greece has 238 hospitals including seven sanatoriums. There are 1,413 hospitals in Italy with a total of 57,120 beds. These figures, however, are not recent. Spain has 1,331 hospitals with 153,867 beds. Ireland has 189 hospitals with a total of 35,783 beds. Canada has 865 hospitals with a total of 73,078 beds. India has 5,486 with 57,789 beds.

Doctor Mansholt, however, points out that the number of hospital beds in a particular country does not give an altogether reliable picture of the provision for the entire people. For the division of beds is nowhere uni-

form. As a rule the larger centers show a much greater percentage than the country districts. Entire districts may be only sparsely provided with hospital space, while the figure for the whole country is among the highest. The number of beds is, to an important extent at least, regulated by the requirements. The inhabitants of the towns go much more readily into hospitals than do those of the countryside.

Doctor Mansholt also traces the development of hospitals in the various countries and points out the difference between the hospitals in Great Britain and the English speaking countries outside of Europe and those on the Continent proper. Public and private hospital organization and management are also discussed.

### High School Training for the Prospective Nurse

High school training for the girl who is planning to enter the profession of nursing should include work in English, in the social, physical and natural sciences, in elementary mathematics and if possible in one or more foreign languages, Dr. William R. Smithey, professor of secondary education, the University of Virginia, said in an address to the Virginia State Nurses' Association.

"It is important," Doctor Smithey continued, "that the girl's high school training should also include work in home economics, but it would be unwise to overstress these practical subjects at the expense of the general cultural subjects. Her high school work in the general sciences should include history, civics, economics, sociology and perhaps elementary psychology; in the natural and biological sciences, biology, hygiene and sanitation, chemistry, physics; and in English, four years of training with special emphasis upon literature.

"I don't believe that any high school should set up a definite prenursing program. The high school training of the prospective nurse should furnish a nonprofessional foundation and should lay a definite cultural basis for the specialized work that belongs to the nursing school of the hospital."

### Making the Hospital the Center of Health Education

If the school building in a community is used as a center of education, then why should the hospital not serve the same purpose as a center of health education for the community?

Dr. Estelle Ford Warner, Marion County Child Health Demonstration, Salem, Ore., asked this question of those who attended the Western Hospital Association meeting at Portland, Ore.

"In the small community where the hospital is centrally located it should be the center for health study and the care of sickness," Doctor Warner emphasized. "It is not out of reason to feel that it should be the headquarters for all health activities, the center of all interests in the prevention of disease. When these activities center in the hospital where a cure is supplied, where people naturally think of going in case of illness, the greater will be the advancement in the promotion of health.

"Why not use the hospitals for a meeting place in matters connected with health?" she concluded.



# Practical Administrative Procedures: Basic Standards for Computing and Comparing Income and Expense

BY JOSEPH C. DOANE, M. D.  
Medical Director, Jewish Hospital, Philadelphia

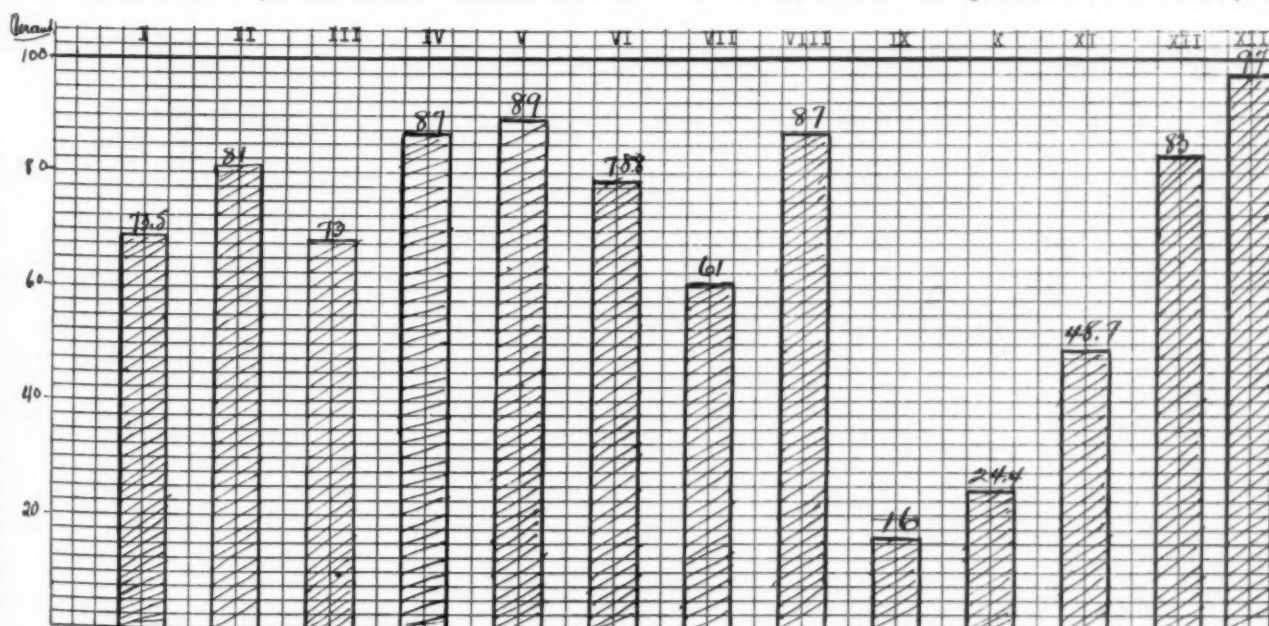
THE place the hospital should occupy in the community has been discussed frequently. It has been said that the hospital should represent a community cooperative venture of the most basic type. If this be true, the responsibility for the proper construction of the hospital and for the maintenance of the plant can and should be divided into as many portions as there are men and women in the community.

Because of this fact, there have been enumerated a number of eminently practical considerations relative to certain financial data that should be at hand before the construction of such an institution is even seriously contemplated. In addition, certain general statements have been made concerning the relationship between the expense of conducting a hospital and the sources and size of its income.

Because the degree of occupancy of hospital beds in a large measure affects the financial success, at least, of hospital effort, pertinent remarks have been made concerning the reasons for low occupancy, as well as the effect of such an unfortunate condition upon the size and regularity of the annual deficit. It has been remarked that the

free care load varies with the type of hospital and with the economic status of its clientele, and that it also varies in direct proportion to the degree of community consciousness possessed by the members of the institutional board. There is no doubt but that many institutions fail to receive the financial and moral support of a community because they, in return, are lacking an ability or a desire to give a necessary amount of free work. This requirement varies widely.

In a certain group of institutions comprising nineteen general hospitals in an Eastern city of the first class, 30 per cent of the patient day service was given to private and semiprivate patients. This type of work may be classified as full-pay since the hospital should not lose money in caring for these patients. Of the ward service, 20, 16 and 20 per cent, respectively, were full-pay, part-pay and free work. While this division of patient days cannot be viewed as a correct and fair average of service to these economic types, taking the field as a whole, yet it may serve to indicate roughly the comparative size of these classes. Therefore, when it is necessary to give free service to more than one patient out of three, the



Graph 1. Percentages of total incomes received from earnings in thirteen hospitals.

administrative officers of the hospital should carefully inquire as to the necessity for spending community funds in this way.

There are, however, many conditions that affect the volume of full-pay, part-pay and free work. Voluntary hospitals everywhere are continually forced to contend with the problem of providing for the out of town free case. Moreover, while it may be assumed that it is illogical to endeavor to define too closely the limits from which the institution should attract its clientele, it may be said that there always exist geographical borders and that patients from beyond these borders should be refused by the private hospital or else required to pay for their care. Such a policy does not brand an institution as mercenary. A proper evaluation and interpretation of the humanities certainly do not contemplate an unlimited amount of free work on the part of the hospital. Attention has been repeatedly directed by sociologic and institutional students to the fact that there is a distinct trend toward the strengthening of the financial policies and toward the improvement of the physical plants of urban institutions, while those hospitals in rural or, at least, suburban districts are finding it increasingly difficult to meet the rising financial obligations of modern hospital service.

#### *Problems of the Urban Hospital*

In a second group comprising thirteen institutions, a marked increase in the number of patients applying for treatment, yet residing in outlying districts, was observed. The total increase in patients treated irrespective of residence was 42 per cent in a five-year period, although the population of the city in which these hospitals were located had increased but 10 per cent. Moreover, as an evidence of the increasing appreciation of or an added need for the institutions of this city, in the same period there was experienced a greater demand for hospital care by the persons actually living in this area. This increase amounted to 34 per cent. Notwithstanding this fact, there was in the same period an increase of 82 per cent in patient days from outside the boundaries of this city. The problem of the voluntary hospitals of this municipality, therefore, is represented by the following percentage demands: 85 per cent of all patient days was given to city residents, while 15 per cent of all patient days was given to those from without the city limits. Of the latter number, 53 per cent were private patients and 47 per cent were free.

Almost every urban group of hospitals in the field has the same problem in greater or lesser

degree. In this instance, 15 per cent of the hospital bed facilities was required to meet the demands of those from without the geographical area served by these institutions. In this particular case, it would seem however, that these institutions, treating as they did extra-urban patients, 53 per cent of whom occupied private or semiprivate facilities, did not lose money thereby. And yet, while less than half of this group were free patients, a large number of bed days were given to its members which might have been and indeed were, in some instances, required by those patients residing within the hospital community.

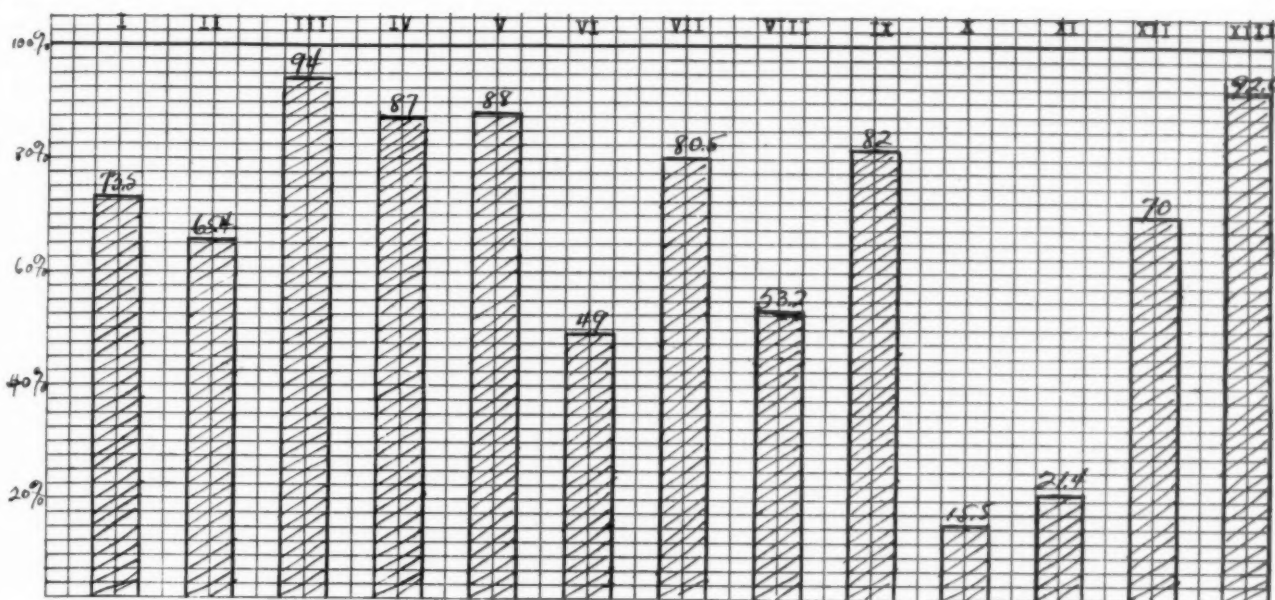
#### *Providing for the Needy*

The problem of securing proper social service investigation of those applying for admission must, of course, include the validating of addresses given by these applicants. In the desire to gain admission to a certain hospital in which they have the greatest confidence, patients will frequently falsify as to their residences. Except in cases of emergency, when such deceit is discovered, these patients should not be accepted. Whenever free patients, coming from without the area served by the hospital, are found to be in need of immediate care, they should be admitted. On the other hand, there should be some arrangement made whereby commissioners or other representative bodies handling tax funds should be required to pay at least the cost price for the care of such indigent persons. In not a few states, it has become the custom for county commissioners, or for directors of the poor to arrange with urban institutions for the acceptance of patients, provisions for which are lacking in their own localities.

It does not appear, therefore, that it is incumbent upon voluntary hospitals to accept all patients who apply, unless the delay necessary for financial investigation would serve as a deterring factor to the patient's chance for a speedy recovery. Of course, this latter statement must be qualified in regard to demands on hospitals conducted by nationally known groups in smaller towns or cities which normally would require but few hospital beds to meet their needs. On the other hand, this group of patients usually is not representative of the free service class. Most hospitals would welcome the application for admission of patients, irrespective of their residences, who are able to pay current private or semiprivate rates, and, hence, to return to the hospital a profit on the treatment they receive.

When private hospitals accept any appropriation from county or state boards in return for a service given to the poor, they expose themselves





Graph 2. Percentages of expenses met by earnings in thirteen hospitals.

to requests for the admission of patients from without their community which are difficult to refuse. These applications are often made by politicians or others temporarily in power. If the applications are granted, the cost of the service may exceed by many dollars the actual amount of the grant. Because of this, many institutions are unwilling to accept such appropriations from the public purse. When such grants are made on a *per diem* basis this practical danger is largely obviated.

From what sources, therefore, is the hospital financed? It may be said that the income of every institution is derived from one or all of four sources: its own earnings, its returns from investments, donations or federal, state or municipal appropriations. In the second group of hospitals mentioned, 73 per cent of the total income was derived from earnings. In the computation of this figure, a large municipal hospital was omitted because the total cost of upkeep was met by funds derived from taxation. In this group, by including the latter institution, but 48 per cent of the expense of these hospitals was met by earnings. Sixteen per cent of the total expenditure necessary for the operation of these institutions was derived from the local community chest.

In a group of fifty-six institutions represented by the United Fund of New York, 70 per cent of the expenses was met by the direct earnings of these institutions. It will be seen, therefore, that approximately \$7 out of each \$10 spent, can be earned by the average general hospital, with the usual apportionment of private, semiprivate and ward beds. It is true that many hospitals are unable, for several reasons, to earn this pro-

portion of their expense. Indeed, the type of institution and the amount of work it performs, as well as a low economic status in its clientele, often will make impossible any near approach to this figure. The average daily income derived from board in a large group of hospitals in New York City was \$2.92 a patient. This sum in the aggregate met 45 per cent of the total operating expenses. A hospital receiving children for orthopedic work, a speciality hospital handling only nose and throat cases, a cancer hospital, several maternity hospitals and, frequently, general hospitals in districts inhabited by the poorer classes are often unable to earn \$1 out of every \$3 spent. In Graph 2 the institutions shown as earning but 15.5 per cent and 21.4 per cent of their expenses were hospitals caring for orthopedic children of poor parents and for aged women, respectively. It is apparent that the nature of the work of these hospitals precluded any possibility of their realizing more than a purely nominal income from their efforts. On the other hand, taking such general hospitals, as they run, it may be said that a minimum of 50 per cent and a maximum of 75 per cent, represent an average range of earnings which is in keeping with good scientific and humanitarian work.

Although the hospital may adopt a fair rate card and may be unusually careful in the social service and medical study available prior to admission, uncollectible debts are all too frequently incurred. In some instances the credit officer is at fault. This is particularly true in cases in which a patient is classified as full-pay or part-pay instead of being assigned to the free group for which the institution should receive a *per diem* allowance from the city or state. In some



institutions the accounting system is inaccurate or else the bookkeeper or clerk is careless. Too often it is impossible to learn the amount of free service given or, if this information is available as a total, subdivisions to classify the sources of the deficit are lacking.

#### *How May Accounts Be Collected?*

Hospital administrators differ greatly as to the methods of collection of accounts that are both ethical and efficient. There is perhaps rightfully some hesitation in employing legal methods in the collection of debts. It is argued that what is gained in money is lost in the unfavorable discussion in the community which inevitably follows the adoption of such methods. Yet the hospital should not be victimized by unscrupulous persons nor should generous contributors be asked or allowed to satisfy debts for which dishonest patients are responsible. Perhaps some cooperative scheme whereby patients who have defrauded one hospital may be prevented from victimizing others in the same community might be evolved. Certainly in the case of patients willing to pay something at the time of admission some part-payment plan should be arranged.

Reference has been made to the type of institution that does not see fit to assume any degree of obligation in the matter of treating the poor. Such a hospital, if its clientele is of sufficient size and wealth, will frequently be able to meet its expense from earnings. Indeed, in some instances, proprietary institutions that are ethical and capable of giving a high grade of medical service, are able to show an actual profit. It is a well known fact that certain well conducted sanitariums receiving psychopathic, psychasthenic or other neurological cases have been known to earn a profit on the money invested of from 20 to 40 per cent. Yet, it is impossible for a voluntary hospital to fulfill its full obligation to the community from a humanitarian standpoint and show anything but a deficit at the end of the year. Indeed, a community institution that endeavors to bring to too low a level the number of beds set aside for ward patients is considered by many to be building on a dangerous basis. If a coal, mercantile or other business should unfortunately find itself unable to meet its financial obligations, the community population no doubt would regret such an occurrence but it would feel no responsibility for it. The hospital must never place itself in the position of a commercial venture, the financial success of which depends only upon the efforts of the members of its board.

The study of hospital rates generally reveals the fact that there appears to be no basic or

standard charge for hospital service. One not informed concerning administrative institutional methods might reasonably wonder whether it is possible for the same degree of service to be given when one institution charges \$6 a day and another charges \$15. Private rooms vary in price from \$6 to \$20 or more per day. Ward rates are in no way standard, ranging from \$1.50 to \$4.50 a day. It is a question that few have successfully answered as to how some equalization of these rates can be brought about. Moreover, the reasoning individual, inasmuch as there is certainly no rational excuse for such a variance, must surely conclude that either the maximum rate is exorbitant or that effectual hospital care is not being purchased by the minimum. Perhaps it might be possible for local groups of institutions to endeavor to standardize these prices more or less. Unfair competition would be thus eliminated and the public would be impressed, at least, by the attempt, no matter how successful, to regulate charges for hospital service.

The distraught hospital administrator who is trying to find and to eliminate preventable leaks, and to minimize expense without curtailing good service, may find a comparison of *per diem* costs and incomes helpful. It would seem that an attempt to deal in units rather than in gross amounts would be informative not only to members of boards of trustees but also to the public generally. In a certain group of institutions, it was discovered that the average daily cost was \$5.49. This was for a service given by about 2,000 beds. The average loss per day per bed on this venture was \$1.77. Further examination of the source of such loss might reveal the exact location of certain deficit units. From this information, it should be possible to reduce the aggregate by eliminating or minimizing the component parts.

#### *Few Have Accurate Cost Accounting Systems*

Few institutions have been able to establish accurate cost accounting systems in their out-patient departments. Indeed, many hospitals have been unable to separate the cost of conducting the out-patient clinic from that of rendering service to in-patients. It has been estimated that about as many visits to dispensaries are made in a year as there are inhabitants in the district served. In an institution with a small bed capacity, the burden of conducting the out-patient department, when prorated to the individual bed, increases the per capita in-patient cost. Hospitals vary greatly in their out-patient department cards. The charge for the first visit often varies from twenty-five to fifty cents, or a range of 100

per cent. The charges for revisits vary from ten to twenty-five cents. In some institutions, special fees are exacted which vary in as great a degree. For example, the charges for medicines may range from twenty-five cents to one dollar; for x-ray service, from \$1 to \$20; for physiotherapy, from twenty-five cents to \$3; for dressings, from twenty-five cents to \$1; for laboratory fees, from twenty-five cents to \$5; for arsaphenamine, from fifty cents to \$1; and for insulin, from sixty-five cents to \$1.25. It may be seen readily that there is no basic rate for out-patient charges and that the principle upon which many institutions appear to conduct this work is to secure as much money as possible, dependent upon the ability of the patient to pay.

#### *When Statistics Are Helpful*

Certain ethical considerations should enter into this matter of charges. What percentage of profit is permissible in the dispensary, if insulin, for example, costs forty-eight cents per 100 units? Is the dispensary justified in charging \$1.25 for it? It would seem that if the patient possesses an ability to pay a fee in excess of the usual amount charged that he should be sent to a private physician and that treatment in the dispensary should be refused. It is, of course, a difficult matter, when treatments are administered to out-patients in the therapeutic departments of the hospital, to separate the costs for and the income from such treatments from those incurred and received in the treatment of in-patients. Yet it is impossible to compute dispensary costs and incomes unless this is done. In one study, it was found that the average income from dispensary visits varied from one to eleven cents a visit. The income from the dispensary will depend, of course, upon the size of the charges made and upon the type of dispensary conducted. From the diagnostic clinic, for example, one would expect a greater return than from a dispensary in ordinary. The earnings of the hospital, therefore, will consist of the sum total of departmental returns, and in the same way its losses may be apportioned to these departments.

In a study of hospital expenses, only a few generalities may be safely made. The comparison of per capita costs, for example, is illuminating usually only from the standpoint of observing their great variance. Until some standard is adopted generally for the computation of such costs, they will be more often misleading than helpful. Yet not more than fifty cents of each hospital dollar should be spent for salaries and not more than twenty-eight cents for food.

It is sometimes a good plan for the superintendent to endeavor to reduce the per capita cost to unit quantities. In one institution, for example, it was found that eight cents of each dollar was spent for administration; seventeen cents for professional care; eight cents for medical and surgical supplies; two cents for x-ray; three cents for laboratory; twenty-eight cents for food; eight cents for housekeeping; four cents for laundry; sixteen cents for plant operation and maintenance and only seven mills for social service. One would infer from a study of these statistics that social service work was being neglected while most of the other unit expenditures were more or less in line with the usual experience. Such information should be of the greatest use, moreover, in presenting the case of the hospital to the community. When the average lay person considers the amount of money he is required to spend to procure food for his own family, he is aghast at the ability of the hospital to feed the patient for twenty-five cents a meal. It is much more easy, therefore, for the public to comprehend statistics of this sort, than it is to understand and approve the expenditure of a bulk sum of many thousands of dollars for various necessary commodities.

It has been the aim in this sketch to point toward certain basic standards for the computation and comparison of hospital income and expense figures. The statistics given have been presented from an illustrative standpoint, rather than for reference purposes. They represent, in some instances, a small cross section of the experience of an isolated group of institutions. On the other hand in many instances they are sufficiently accurate to be used comparatively in the solution of local hospital problems.

### Necropsies Increase in Chicago Hospitals

A gratifying increase in the number of necropsis secured in the hospitals of Chicago is reported to the governors of the Institute of Medicine of Chicago, according to the *Bulletin of the Chicago Medical Society*.

The percentage of permission necropsies for all hospitals who answered the questionnaire sent by the institute was 24.1 for 1928. Omitting the figures for the Cook County Hospital, there were 2,072 permission necropsies and 764 coroner's cases in 8,501 deaths, 26.8 per cent permission, as against 1,647—20.9 per cent—in 1927 and 1,125—21.1 per cent—in 1926.

In computing percentages of permission necropsies for 1928, the figure taken was for the number of deaths—not including stillbirths—minus coroner's cases.

In twenty-eight hospitals the percentage of permission necropsies was 20 or more.

Fifty-two hospitals in Chicago responded to the questionnaire.



# Editorials

## Why People Complain About Hospital Bills

“WE MUST look at the hospital bill from the point of view of the patient's pocketbook and not merely from that of the hospital exchequer,” writes a critic of the article in last month's issue of this magazine, “What 10,000 Patients Actually Paid in 100 Hospitals.”

It is quite true that the reasonableness of a hospital bill does not depend solely upon its amount. It depends upon the amount in relation to the patient's ability to pay. Our critic might have gone on to say that from the point of view of the patient's pocketbook, the professional fee must be taken together with the hospital bill because, after all, the patient is interested in the total amount that he has to pay and only secondarily in the subdivision of the bill among different items or agents. In a twelve-day surgical case, for instance, \$75 to \$100 might easily cover all hospital charges but the surgeon's bill would rarely be less than \$100 and might be \$150 or more, even for a patient of moderate means. If the patient complains, it is likely to be because of the size of his total bill and whether he complains of or to the hospital may be determined by reasons that are more incidental than important.

Another source of burden to the patient that might have been brought out in the article is the uneven distribution of the expense of hospital care among any group of patients. In any given year, serious illnesses such as require hospital care, fall upon only a small proportion of individuals and families and the high-cost illnesses (which are those that really matter) befall a still smaller fraction. The figures on page 62 of the January issue, for example, show the amounts paid by different patients for hospital care and the number of patients out of 100 paying these amounts. The 100 patients altogether paid for their hospital care \$6,517. This is an average of only \$65 apiece. That seems moderate indeed. But when the distribution of this amount is considered, the picture is very different. Eighty-one cases out of 100 paid a total of \$3,155 or 48 per cent of the total. The remaining nineteen cases paid \$3,362. In other words, less than one-fifth of the patients paid more than one-half of the total expense. The sources of complaint and of

real financial difficulty lie chiefly in the 15 per cent to 20 per cent of families upon whom the more expensive illnesses fall. There is no guarantee that the high-cost illnesses will fall upon the high-salaried families. The hospital world may well give thought to methods of equalizing things by systems of installment payment or by insurance. Let us try to distribute burdens and not blame.—M.M.D.

## Care of the Infirm and Aged in Rural Districts

THE almshouse of a half century ago, with all of its administrative incompetence, its abuses and its neglect of the mere decencies of life, fortunately has largely disappeared from the midst of urban communities. Notwithstanding, however, a rising per capita wealth, dependent sick persons are still to be found in every community.

Such unfortunates are often housed in sanitary and fireproof buildings, yet too frequently the stench of political interference in the management of such institutions assaults the nostrils of an otherwise progressive community. Nevertheless, while scant funds are usually available for the care of the community's poor, the lot of the indigent everywhere has been humanely softened in past years. The almshouse infirmary in large urban institutions has now assumed the proportions of a more or less well equipped hospital. The almshouse proper has frequently been separated, actually as well as administratively, from the buildings housing the sick and has been conducted as an entirely distinct institution. Such a cleavage is most fortunate because pauperism usually begets an attitude of hopelessness and of passive submission to the principle that the most meager attention is sufficient for the man or woman who lives on the bounty of the public. Yet in too many instances such public hospitals represent the lowest ebb of scientific attainment.

Ineffective as are some of the urban almshouses and hospitals, they are perfection when compared to rural homes for the indigent. The “poor farm” is rightfully synonymous in the minds of thousands with all that is hopeless and heartless. The inmates are housed in buildings often veritable firetraps, with wooden floors reeking with the odors of grease, cheap soaps and deodorants or redolent with the stench of urine, and there is little wonder that a trip “over the hills to the poorhouse” is viewed as the beginning of a living death.

The infirmary, supervised by a sometimes kindly,



often calloused and usually inexperienced woman, is cheerless, odorous and hopelessly drab. Yet to such a destitute environment, surrounded by an indiscriminate collection of human derelicts—idiots, the insane and vicious—must come men and women of finer fiber who have been overtaken by age or by chronic illness while yet unprepared to provide for themselves financially. Such a calamity is far too common in hundreds of counties and cities in our forty-eight commonwealths.

It is tragically true that in many such communities no adequate provisions for the care of the chronically ill have been made. To require the formerly successful and still refined business or professional man or woman to spend the evenings of their lives amid such hopeless surroundings makes a travesty of our vaunted humanitarianism. If single counties cannot as effectively separate their almshouses and wards for the care of the chronically ill as have their urban neighbors, two or three might combine and provide really adequate facilities for the treatment of such cases. Under the present circumstances, farmers in prosperous grazing sections often care for ailing stock in a far more efficient and intelligent manner than the county commissioners provide for their neighbors who are indigent, to be sure, yet chronically ill.

All right thinking men and women must challenge the justice of any policy or practice that permits the neglect of the helpless sick because they are unable to pay for private care. But rural purse-string holders are loath to increase taxes for any cause; hence, little reform may be expected from within.

THE MODERN HOSPITAL respectfully directs the attention of associations, foundations or philanthropically inclined individuals to the opportunity for service that is represented by a study of this problem.

### Let the Middle Class Act First

**A**NNOUNCEMENT that another major attempt is to be made by an Eastern city to solve the problem of bringing effective medical treatment within the economic reach of the now almost classically denominated middle class is heartening. That the variance in the price necessary to the semiprivate or private care of this group and the amount that it is felt its representatives can pay are to be met by an endowment fund equal to that spent to construct the hospital is an interesting approach to the problem, to say the least.

The members of this group are often deserving, usually self-respecting, yet frequently un-

frugal, but the routine functioning of our social machinery does not make possible the winnowing of the deserving from the undeserving. It is therefore in accordance with good judgment and sound business for society to inquire what steps an individual has taken to aid himself before vouchsafing any assistance. "Save for Sickness" should become a compelling slogan. When an honest endeavor has been made by an individual to provide for the emergency of personal or family illness, then, and only then, should the plight of the middle class demand relief from society in general.

### Are Board Committees Complicating?

**M**ULTIPLICATION of parts in any type of machinery is a vice to be avoided. In the building of a hospital organization the greatest efficiency will often be represented by the simplest graph. Should the board of trustees of the hospital be so subdivided into committees that every function has a number of men and women of the trustee group specifically assigned to supervise this activity?

This is a matter of policy of the greatest importance to the welfare of the average hospital. There is no standard number or nomenclature covering trustee committees. For example, on the organization charts of a certain group of eleven hospitals there were listed thirty-seven different board committees. Indeed the board of one of these hospitals, which housed ninety-seven patients, boasted of fourteen committees. In others, the hospital managed to function with but an executive group to act, if necessary, in the interval between board meetings.

Mayhap the fallacious belief that if one committee is good fourteen are proportionately more desirable may explain this practice. Or on the basis of showing no partiality to any board member, a committee chairmanship for each might be considered essential. Whatever the cause, thoughtful administrators are becoming more and more convinced that a multiplicity of board committees is not an unmixed blessing. Moreover there are many who doubt the wisdom of any policy that delegates too great a measure of purely administrative responsibility to board members.

The chief duty, as well as the most important function of the hospital trustee, is to formulate policies and to provide the hospital executive with the authority to enforce them. He should be content to stop there. The average board member is

not qualified in any great degree by either experience or training to administer the hospital any more than he is to prescribe drugs or to direct the x-ray department. Too intimate contact between board members and the members of the hospital's personnel is likely to beget interference with executive prerogatives and to create friction and misunderstanding.

In some well conducted institutions there is but one subcommittee of the board—the annually elected executive committee. In others two members serve rotating periods as the executive committee of the month. Such a plan has the virtue of bringing to each member a more thorough knowledge than would otherwise be possible of the functionings of the hospital.

A competent superintendent should be able to conduct the work of the hospital more efficiently if committees are few and if he is permitted therefore to serve as the liaison officer between the board of trustees and the hospital personnel.

In not a few institutions the elimination of friction and lost motion would certainly follow the simplification of board organization and the adoption of a "hands off" policy on the part of its individual members, insofar as the administration of the routine affairs of the hospital is concerned.

### The Appreciation of Hospitals

**T**HE hospital of to-day is a relatively new thing, so new that the general public has not become hospital-minded. To the average citizen a hospital is a place of torture and extortion and it is only as a last resort that he can be persuaded to enter a hospital for treatment. When he does enter, he is apt to misunderstand many of the things that are done for his benefit, and if he is held for a period of observation without any drastic treatment by the gastrointestinal route, he is quite apt to be extremely critical of the hospital and its methods.

Perhaps the thing that the patient resents most keenly of all is the sum total of the bill. Too frequently hospitals lump the entire bill, including the charges for the physician, the nurse and all extra fees, under one head. Other hospitals itemize these amounts, but the bill is presented by the hospital and the patient confuses the amount that he has to pay the doctor and the nurse with the charges that are actually made by the hospital.

A great many suggestions have been made as to the methods to be employed in combating this attitude of the public mind. There is no single method that will prove a sovereign remedy. The

basic principle, however, is the education of the general public to a proper appreciation of the hospital. A most important way to do this is by refusing to lump the bill—that is, to present the patient's account in such a manner that he will understand definitely what the hospital per se has cost him. Well written editorials in the public prints, addresses before the various service clubs and many other publicity methods will be of material assistance.

### Strength in Unity

**H**OSPITALS are notoriously jealous of their autonomy. They are prone to look with suspicion on those who suggest any form of cooperative venture in which a policy forming group is brought into even advisory contact with hospital administration. Institutional boards usually possess a laudable pride in the rendering of service that they deem unexcelled. And yet there has been attained no ultima Thule, no point of perfection, in the service to the sick. Inflated local pride is too often anesthetic in its effect on a striving for better and more efficient business and scientific administration of the hospital. Self-satisfaction is often but an evidence of a somewhat rural complacency toward the methods of administration employed in other and more advanced medical centers.

That an organization of community institutional resources represents but an act of ordinary good judgment is recognized by many. In cities possessing half a dozen or more institutions the formation of a hospital council has aided in solving many troublesome problems. Thus, unfair and harmful competition has been minimized by an attempt to standardize hospital rates; specialization in the treatment of certain types of patients requiring an unusual outlay of money for personnel and equipment possessed by one and not by others has proved efficient; the repeated abuse of the hospital's generosity by malingerers or others able to pay has been checked. These and many other ends may be gained by the intelligent and constructive effort of the members of a hospital council. And yet the organization of such a body is not always easy because of local jealousies or suspicions.

The contributing community will not continue indefinitely to approve such an unprogressive attitude in hospital work. No hospital has a right to exist which is in but not of the community. An institution does not merit either the support or the confidence of a town if it is not willing to subordinate self-satisfaction and pride to the good of the whole community.



# Abstracts of Hospital Literature From Foreign Countries

A Department Conducted by E. M. BLUESTONE, M.D.

Medical Director, Montefiore Hospital, New York City

## I. "LIBRARIES FOR PATIENTS IN HOSPITALS," *Irmgard Linde, Berlin*

Attention is called to the importance of selecting adequate reading material for patients, especially chronic patients. A survey of the fifty-seven hospitals of Berlin and of the larger institutions in other German cities revealed that all of the municipal hospitals possessed libraries ranging in size up to 2,000 books. The sterilization of books is undertaken by means of a sulphur preparation and formalin vapor and by heated air. Some of the hospitals do not approve the sterilization of books and systematically destroy those books that are under suspicion as possible carriers of disease. The article emphasizes the importance of selecting a librarian who is socially minded and who is sympathetic with the needs of the patients.

## II. "THE REBUILDING OF THE SURGICAL CLINIC OF THE MUNICIPAL HOSPITAL, MAGDEBURG-SUDENBURG," *Professor Wendel, Director*

For years the surgical department of the Municipal Hospital, Magdeburg-Sudenburg, Germany, had been in a pavilion not especially built for surgical purposes. Although retarded at first by the war, the municipal authorities managed finally to put an end to this provisional state of affairs. They decided to rebuild the surgical department, the plan of the new construction being to combine the latest architectural developments with the newest applications of scientific progress.

According to an article by the director of the Municipal Hospital in *Zeitschrift Für Das Gesamte Krankenhauswesen*, the first plan was to build the surgical department on three lots, these lots to run parallel to each other. The department, to be built in the north axis of the hospital, was to have a capacity of 300 beds. Lack of money, however, forced the municipal corporation to drop this plan. Construction was, therefore, confined to one lot only. The first matter to be considered

was the operating section. It was to have as many wards as possible. All cases of aseptic surgery were to be collected in one group. On the ground floor the technical equipment was to be assembled. The original idea of using the three lots for later expansion was kept in mind by the municipal architect, Göderitz.

### *Features of the New Clinic*

All of the wards were designed to face south, while the technical and service rooms were designed to face north. The doctors in Magdeburg are of the opinion that strong light must be avoided by patients who have recently undergone operations. They refrained, therefore, from using the same shape and size of windows in all of the wards.

Some of the noteworthy improvements in the new surgical clinic are: Each ward is provided with a large veranda which permits the beds to be moved out; a flat roof, accessible by an elevator, has been provided as a roof garden. This arrangement, of course, does away with attic storage rooms. While there is some loss, naturally, there is no doubt but that the roof space is best employed for patients, the author says.

Several important features that were considered specially desirable included: the concentration of all rooms connected with surgery and preparation for surgery—the x-ray laboratory, the research laboratory, the general laboratory, the lecture hall and the sterilizing rooms and outpatient departments; as much privacy as possible for the operating room and its surroundings; convenient and quick transport for patients; no disturbance to patients in the wards. The first two were achieved by adding a special section north of the building, the so-called "operating section" on the ground floor. The operating department can be completely locked against the rest of the building which guarantees undisturbed work.

Transporting the patient to and from the operating rooms in bed necessitates exceedingly spacious lifts suitable for carrying a bed and the accompanying attendants. The chief advantage



of these spacious lifts is that the attendants do not have to lift and let down a patient several times before and after an operation.

Separate staircases for each of the three stories prevent crowding of visitors. The ceilings have been built strongly and, therefore, have great carrying capacity. This will make it possible eventually to remodel the wards and change the size of the rooms when better financial conditions in Germany enable the hospital to carry out its original plans.

### III. "THE LAUNDRY IN HOSPITALS," O. Neumann, Engineer, Berlin

*Zeitschrift* publishes this study of the comparative merits of two kinds of mangle—(a) the steam heated cylindrical flatwork ironer in general use in this country and (b) the so-called "mould" mangle, a special German machine which works on the principle of the ordinary flatiron. Both of these machines have their merits, but the first is preferred.

### IV. "REPORT OF A COMMITTEE OF THE ASSOCIATION OF FEMALE SUPERINTENDENTS ON PROFESSIONAL TRAINING"

As a general rule women superintendents of hospitals in Holland are subordinated to the medical director. They have a twofold function in that they are intrusted with the supervision of the household and with the supervision of the nursing department. The report of this committee recommends: a high school education, a certificate from a school of nursing, a thorough knowledge of maternity nursing and nursing of the mentally ill and preliminary work in executive duties. The university extension classes should be organized in social work and in the principles of housekeeping, and hospitals should give courses in the construction, organization and administration of hospitals.

### V. "THE STATE NURSING ORGANIZATION OF ARNSDORF IN SAXONY," Rector Wehrmann, Arnisdorf

This state institution is unique in Germany. Nurses of this corporation are state officers with all of their rights and duties guaranteed by law, including salary and pension allowances. The corporation was originally organized to supply mental institutions with nurses. The training of student nurses is completed in two and one-half years, when the graduate is expected to pass the state board examinations.

### VI. "COLOR SCHEMES IN HOSPITALS," Dr. W. Crodel and Fritz Schaeffler, Artist

The authors begin with a quotation from the German poet, "*Gefühle sind Sterne, die nur bei klarem Himmel leiten*," and present a scientific treatment of the subject with characteristic German thoroughness. The scene of their activities was the medical clinic at Kiel. The standardization of colors and their grouping and harmonizing are given extensive space. Three fundamental principles in esthetic research are emphasized: (1) clearness in psychical impressions, (2) the knowledge of color combinations and (3) a rhythmic return of contrasts both as to color and as to shades and shadows.

After an extensive discussion of the handling of color materials, the authors discuss the esthetic effects of color schemes. The literature in this field is reviewed, including the manual published by the poet Goethe on the effect of colors. The various aspects of esthetic effects are described in detail from one end of the spectrum to the other and, in accordance with various combinations of colors, an elaborate schedule is presented indicating the effects on sensation. The article has a section on color schemes in hospitals which emphasizes the development of a chromo-therapeutic scheme to inspire the patient and lessen his fear of the hospital, thus contributing to the healing process.

Color schemes for the sexes are given their place. Women's wards, the article says, should have warm colors and weak color harmonies. In men's wards, on the other hand, a more active, somewhat richer color scheme is advisable.

### VII. "NEW APPLIED ART," Hermann Distel, Architect, Brandenburg, in Cooperation With A. Grubits, Architect, Berlin, Germany<sup>1</sup>

"New Applied Art" by Hermann Distel, official hospital architect of Brandenburg, Germany, in cooperation with A. Grubits, architect, Berlin, is a book mainly of illustrations of the work of these two architects. The book is published by F. E. Hubsch, with a thirty-one-page supplement and an introduction by Dr. C. A. Piper. Mr. Distel recently visited America as one of the delegates to the International Hospital Congress.

A study of the exteriors of recently built institutional buildings, to which this book is mainly devoted, shows clearly that German architects are making a conscious effort towards finding new forms of architectural expression. The results are frequently interesting and sometimes successful.

<sup>1</sup>This review of "New Applied Art" was written by Robert D. Kohn, architect, New York City.

ful. On the other hand, these plans of recent German hospitals and other institutions indicate little that is suggestive to an American designer. Partly because of lack of money but mainly because of an entirely different social viewpoint, these institutions seem poorly provided with the amenities of living. They are doubtless technically quite correct and suited to the standards of living of the patients but they are meager and a bit cold-blooded according to American standards. But none the less it must be acknowledged that Distel is one of the men who are doing interesting work in discarding outworn forms and traditions and this book is an evidence of his considerable accomplishment with small means.

VIII. "THE HOSPITALS OF THE EAST COAST OF SUMATRA," Dr. W. Kouwenhaar, Director, Pathological Laboratory in Medan

Seventy years ago the east coast of the Island of Sumatra was a sparsely populated and waste territory in Dutch East India. The discovery of fertile soil for the cultivation of many tropical plants, particularly tobacco and rubber, brought great prosperity. Because a sufficient supply of labor could not be obtained from the native population, coolies had to be imported from Java and China. Until the end of the nineteenth century the mortality from all kinds of tropical diseases was great and replacements had to be brought at a high cost, which, in turn, threatened the prosperity of the country. Professor Schüffner, who was at that time physician to one of the big tobacco estates, succeeded in convincing the community of the desirability of instituting proper public health measures to curb the high morbidity and mortality rate among the population. Hospitals and health stations were established to prevent and cure disease. From that time the mortality among immigrants fell from 10 per cent per year to less than the mortality of West European populations. A by-product of this activity was the revival of some of the estates that had fallen into economic disorder by the deficits incurred in consequence of the mortality. The author argues that there is no more striking example of the economic value of public health than is shown in the case of the Dutch East Indies.

In the course of time forty-two hospitals of varying capacity up to a maximum of 800 beds have been established in a limited territory. In Medan, the central town of the territory, large pathological laboratories, quarantine stations for 1,000 immigrants and a European hospital came into being. In the mountains near-by there are

convalescent homes and an institution for the treatment of leprosy.

The author describes some of the hospitals owned by large tobacco and plantation companies. All of the hospitals are built in the pavilion style and are situated on large plots of ground. The buildings for the most part consist of a main building, a building for the reception of patients, laboratories, x-ray and surgical departments, ward pavilions with separate rooms for Europeans, wards for infectious diseases and residences for the personnel. In addition there are the water towers, laundry, septic tanks and mortuaries. The description of these hospitals is extensive and the author gives a clear view of hospital functions in a tropical country. The article is richly illustrated. The editor remarks in connection with this article that hospital accommodations in the Dutch East Indies are among the most complete to be found anywhere.

IX. "THE HOSPITALS OF AMSTERDAM," J. L. C. Wortman, M.D.

In this article in *Het Ziekenhuiswesen*, two private hospitals are described and illustrated. They are the Nursing Home of Prinsengracht and the Boerhaave Clinic. The first of these two hospitals is managed by a committee of prominent Protestant men and women. Throughout the years it has been considered an aristocratic hospital of a high type. The treatment of surgical conditions has become more and more the main object of its interests. It is for this reason that a large operating wing with a capacity of fifty-five beds has been added, somewhat out of proportion to the remainder of the hospital. The Boerhaave Clinic also enjoys a high reputation. It is situated near the Ryks Museum at Museum Square.

X. "DWELLING PLACES FOR ADVANCED TUBERCULOUS PATIENTS IN STUTTGART," Dr. Fuchs-Roll, Town Architect, Stuttgart

Several German cities decided during the last few years to build separate dwelling places for patients suffering from pulmonary tuberculosis. These houses are inhabited by patients who live with their families. In Stuttgart, a broad municipal plan was evolved which consists of a complex of five buildings, each constructed to house several families. Besides the ordinary arrangement and equipment of the residence for healthy persons, there are separate floors with covered verandas for the sick. The buildings are located at different levels on the side of a mountain ridge.



## YOUR EVERYDAY PROBLEMS

*A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.*

[No attempt has been made to offer final conclusions relative to the questions considered in this department. **THE MODERN HOSPITAL** will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

### How Can the Credit Department of a 125-Bed Hospital Reduce Losses?

A superintendent in an Eastern hospital asks this question. The institution is a general hospital which averages eighty-six patients a day throughout the year. The credit officer is a woman with a nursing training. The hospital is functioning under a budget system formulated by the welfare department of the state in which it is located. In the course of six months' functioning, \$3,000 in bad debts accumulated. As a result, the hospital lost its opportunity of securing a per capita recompense from the state for free service.

If the credit officer depends entirely upon a brief interview at the hospital for the classification of patients from an economic standpoint, the institution is bound to lose money. The attitude of some persons who justify to their own satisfaction, at least, attempts to defraud the institution of money rightfully due it is surprising. An inspection of the institutional parking place might disclose that persons who suddenly have become so poverty stricken upon entrance to the hospital lobby that they cannot meet a moderate board bill have driven to the hospital in an expensive car.

The credit officer of any hospital must be an unusual combination of detective and humanitarian. He must be moved to practical sympathy by the distraught personalities who approach his desk, but at the same time must possess a certain understanding of human nature that will prompt him to discount, under proper circumstances, the statements to which he listens.

In the instance cited here, the credit officer certainly was too hurried or too gullible properly to diagnose the economic condition of patients whose aggregate board bill represents this loss. If the probability of defaulting in the payment of these obligations could have been more accurately gauged, the institution stood an even chance, at least, to be recompensed for a part of this service through state appropriations.

The social service department of this hospital performs only medical work. No financial investigator is available to visit the homes of patients and to obtain first-hand information concerning their financial condition. It would seem that valuable credit information could be secured as a by-product of the visits of the social worker. True it is that medical social workers involved rather avoid the business of financial investigations. To make such work a major activity on the part of the social service department is wrong. A visit

of the credit officer to the homes of patients in conjunction with the social worker might be illuminating to both and of financial advantage to the hospital. To require payment of board in advance appears some times inhuman but such a practice may be safely followed when the good faith of patients and their relatives is in doubt. Many hospitals hesitate to attempt to collect accounts due them, yet when definite commitments by patients or their relatives have been made, such a step is but an exemplification of good business.

**THE MODERN HOSPITAL** might suggest in this instance that if failure to diagnose the economic probabilities of patients and their relatives is chronic in this institution, the superintendent should perhaps endeavor to secure an employee with a keener business vision than the one who now heads this department.

### What Should Be the Organization and Personnel of a Laboratory in a 125-Bed Hospital?

A superintendent of a hospital in a Midwest city has experienced some difficulty in making the contribution of the laboratory of his institution what he thinks it should be. In this particular hospital, about 10,000 examinations a year of all sorts are being made. Its personnel consists of a half-time director who receives \$4,000 a year, two technicians who receive \$1,500 a year each, an intern and a deiner. The question is asked as to whether the amount of work being done in this laboratory justifies the expenditure of this amount and whether a hospital of this size should not be doing much more work than is the case in this institution.

Institutions in suburban or rural districts experience a great deal of difficulty in bringing about the proper use of laboratory facilities by the visiting staff. Particularly is this true when interns are not available or when the size of the resident staff is inadequate. In the hospital to which reference has been made about 2,500 patients are admitted annually. Four examinations per patient would appear to represent an insufficient laboratory study, particularly as all types of work are included in this figure. About ten urinalyses a day are done in the laboratory mentioned here. The number of blood counts and the amount of blood chemistry studies are also equally inadequate. When the number of examinations is reduced to a daily average, it can be seen that about thirty tests a day are being carried out in this institution and that since there are four workers, full and part-time, this means that seven tests a day are expected of each worker. This figure, reducing the proportion as it does to an absurdity, would seem to indicate two facts—that the laboratory in question is not being properly used which means that the patients in this institution are being inadequately studied, and that the hospital is spending far too much money for the accomplishment of this work. Such a personnel should be able to perform twice or thrice as much work as is now required of it.



### Under What Circumstances Should a Patient Be Transferred by a Visiting Physician From His Own to Another Hospital?

This question is asked by the superintendent of a hospital in the East who in explanation of his question furnishes the following background:

In a certain hospital, a member of a distinguished family was admitted for treatment. His condition was illy understood on admission and a number of leading consultants were called. A diagnosis was finally reached. The condition to which his illness was ascribed required a specific kind of therapy. The family insisted upon the most outstanding man in the community being called to administer the treatment. The hospital in question possessed a skilled and efficient operator but it could not, however, boast of having on its roster the most widely known physician in town in this specialty. The patient was transferred from the institution in question to another hospital. It was, of course, a matter that gave the superintendent a great deal of concern because a patient of such prominence, after spending ten days in his institution, should be removed to another hospital nearby. The first hospital was mechanically as well equipped as the second and the qualifications of the therapeutic specialist in this institution and his ability to treat the patient as successfully as anyone were not in doubt. It was thought by some that the physician in charge of the case should have insisted more strenuously than he did on retaining this patient in his own hospital. It was believed that perhaps further arguments should have been advanced to show that his institution was capable of finishing the treatment it had begun.

As a last resort, in order to avoid moving a patient who was admittedly critically ill, the distinguished physician to whom the case was referred, might have been requested to come to the institution to administer the treatment there. It was not felt that there was distinct disloyalty on the part of any of the physicians concerned, only perhaps a too prompt acquiescence to the request of the family for his removal to another hospital.

It should be the aim of every institution to be so completely equipped in personnel and apparatus that no matter what therapeutic need might arise, it can be safely and efficiently met. In order to satisfy the family of this patient, it would perhaps have been better to have requested the desired physician to visit the institution and administer the treatment there. In this particular instance the advisability of such a policy was later proved, since the evident fruitlessness of this attempt at a cure was evidenced by the rapid decline and subsequent death of this patient within a few days after he left the hospital.

### How Much Milk Should a Hospital Having Seventy-Five Patients and Fifty Nurses Use?

It is difficult to answer this question accurately. The type of hospital, the grade of its clientele, the degree of economy necessary and the efficiency practiced are all factors that have a distinct bearing on this subject. In some instances a careful dietary has been worked out that permits a definite amount of milk for each liquid diet and for each nurse or employee for each day. In some hospitals, from twenty-five to thirty ounces of milk a day are allowed for each person. In this figure, of course, are included liquid diets with second or third hour feedings. Often an unlimited amount of milk is permitted upon the tables of employees and nurses.

In one institution which averages seventy-five patients

and 115 employees of all types, eighty quarts of milk a day are bought. In a hospital whose clientele consists of a considerable percentage of children or malnutrition and tuberculosis patients, the need and justification for the use of a greater amount of milk are certainly to be found.

It would appear that in the institution from which this question comes a study should be made of the amount of milk being used by employees and patients and a standardization of the amount allowed should be made effective. It would seem that if the proportion of milk per person as cited in the foregoing paragraph is correct, a hospital of 125 beds should be able to function with between fifty and sixty quarts of milk a day.

### Should a Hospital of Less Than Seventy-Five Beds Possess a Dispensary?

This question has come to THE MODERN HOSPITAL from the president of a board of trustees in an institution of seventy-five beds in a rural community. The members of the visiting staff of this hospital are frankly opposed to providing dispensary facilities because they claim that such an activity would attract patients from their office practices. The superintendent of the hospital and the members of the board of trustees, however, believe that no institution is complete without the connection between the home and the hospital that the dispensary affords. The claim that a hospital dispensary is injurious to the practice of individual physicians is in no way new. Indeed, many institutions have been forced to overcome or frankly to defy that opposition before an out-patient department could be established.

There is no question but that local conditions greatly affect the advisability of establishing a hospital dispensary within the community. In the community in which there is no poverty, there is not the same need for the out-patient department as in industrial localities in which a less opulent class of people lives. It is difficult, however, to find a general public hospital in almost any community in which there is not a certain definite percentage of patients requiring follow-up care. THE MODERN HOSPITAL has stated repeatedly that no matter how fine is the scientific care afforded within the institution, the service is not complete unless patients are being followed into their homes to make sure that they are following the precepts preached in the hospital.

To be sure, in small communities real dispensary work is being done by physicians in their offices. No doctor is able to practice medicine without performing a certain amount of free work. Such care, however, is expensive to the physician and perhaps not as effective from the standpoint of the patient as is the organized work of the hospital out-patient department. In a town of from 8,000 to 10,000 population with a surrounding rural community, it would appear that a hospital should conduct a dispensary on some scale. It may be but a single room with but one member of the resident staff representing the personnel, or it may assume the proportions of a well organized and developed out-patient department conducting clinics daily.

It would appear that a hospital of seventy-five beds, situated as is the institution to which reference has been made, should possess out-patient facilities in keeping with the needs and demands of the community. These could be later developed and expanded as requirements demand. Certainly preventive precepts could be more effectively preached in such a department than in the ward in which the patients are actively undergoing treatment.

### Is It Ethical for the Visiting Staff to Tell Its Grievances to the Board Without the Knowledge of the Superintendent?

This is a problem that presents itself in various guises in many hospitals. If the institution is being supervised by a lay superintendent the visiting staff sometimes justifies its action in thus ignoring the executive by claiming that the superintendent is ignorant of medical procedures. Still the basic rule of organization *THE MODERN HOSPITAL* has often stressed is, and should be, operative.

In many institutions a medical executive committee, of which the superintendent is at least an ex officio member, functions in filling a liaison capacity between the staff and the board of trustees. If complaints are made to the medical executive committee and the administrator is in attendance at its meetings, the matter under discussion can be threshed out there before it reaches the board of trustees. A well informed and ethical board of trustees usually insists that all such grievances be presented to the superintendent for transmission, with his recommendations, through the proper channels. If the board of officers is not administratively minded the position of the superintendent can easily be made untenable. Grievances of the medical staff should be presented in writing to the superintendent or to a medical executive committee and a copy sent to the superintendent so that he may be informed as to the details of the complaint prior to the meeting at which it is to be discussed.

The entrance of personalities into hospital work, which is sure to take place under the above circumstances, is so harmful that drastic measures are justified in preventing this calamity.

### How Can an Institution That Has Had a Rotating Staff Change to a Continuous Service?

Any hospital that has had a rotating service with a quarterly or semi-annual rotation in the visiting staff has upon its roster more physicians than it could accommodate were all the services of twelve months' duration.

When an institutional board of trustees becomes convinced that it is to the advantage of the patients and, hence, of the hospital for all services to be continuous, a difficult problem arises.

There are two methods that may be adopted to bring about this change. The first, which requires but little time, would be to fail to reappoint a number of physicians and thus bring the visiting staff roster within the possibilities of a continuous all the year service. The second scheme, which would require a number of months or years to consummate, contemplates, upon the death or resignation of staff physicians, the withholding of the appointment of other physicians to fill these places. The latter scheme while more tedious is less painful to the self-respect and pride of physicians who may have given long and faithful service to the hospital. Hence, it is probably the one of choice.

The strength of any hospital organization lies largely in creating and maintaining a high morale in the visiting staff. It is from these physicians that the hospital expects to receive much of its patronage. From a mere financial standpoint, therefore, the hospital cannot afford to offend the members of its staff unless they are guilty of some misdemeanor that requires severe disciplinary action. From the standpoint of ordinary justice, moreover, it is unfair, because there has been a change of policy, to forget entirely the debt the hospital owes to the individual members of the staff for past services.

When a service is busy and bed accommodations are ample, it may be possible to place more physicians on duty over a period of twelve months than was formerly the practice. In this way, provision for the excess of staff incumbents may be made. It is more difficult under these circumstances, however, to keep physicians active and interested who do not have a sufficient number of patients to occupy their time fully on their daily visits.

Moreover, the adoption of a senior and junior system is likely to prove humiliating to physicians who have served over a long period of time, and yet who are in reality juniors to others who have been attached to the hospital a greater number of years.

Probably the best plan to adopt to bring about this change is gradually to extend three-month periods of service into six months' service, finally reaching the continuous type of service without making enemies for the hospital.

It would be folly for any board of trustees, because the authority is in its hands, peremptorily to drop staff physicians because some other hospital had found a continuous service to be most efficient.

### Have Undertakers the Right to Request a Change in Postmortem Technique?

The problem of securing a large percentage of postmortem examinations is one that faces every institution which receives interns for training. Recent requirements of certain national medical and surgical organizations demand a minimum percentage of postmortems. One of the chief obstacles to this goal that is met in many communities is the obstructive attitude of the undertaker. In some districts where a single outstanding hospital exists the problem is not so vexing. In large cities where there are many hospitals and more undertakers, serious difficulties are encountered. Hospital associations should endeavor, if possible, to learn whether any policy followed by local institutions generally is unfair or inconsiderate of the rights of the local embalmers. Not infrequently the nature of postmortem technique is so faulty that undertakers have a real cause for complaint. The preparations of bodies for burial following a postmortem examination is without doubt more difficult for the undertaker. If there is much delay on the part of the hospital in the execution of death certificates, objections should be made.

In one city, a hospital association and an embalmers' association have for a number of years held a joint meeting at which time matters of common interest are discussed. The matter of postmortem incisions, the leaving long of certain vessels useful for injection as well as other details of importance to the embalmers are discussed. Articles of agreement have been drawn up in which the hospitals promise to adhere faithfully to definite rules covering the performance of autopsies and the members of the undertakers' association agree to do all in their power to forward the work of hospitals in securing permission for postmortem examinations. This plan has brought about an increase in the postmortem percentages in several of the institutions affected and has obviated much of the complaint that formerly existed on the part of the undertaker.

Low postmortem percentages exist only because of a lack of organization on the part of hospital officials. The undertakers can be of much service in securing postmortems and usually are willing to do so if approached in the proper manner.



### Has the Board of Trustees the Right to Refuse to Admit Influenza Cases to the Hospital?

A superintendent of a New England hospital during the recent semi-epidemic of influenza has been much distressed because his board of trustees did not permit the admission of influenza patients to the hospital and because members of the visiting staff persisted in admitting such cases under a false or at least an evasive diagnosis. There is no question but that a board of trustees has the authority even if it does not have the moral right to refuse to admit any type of case to its institution. It would seem, however, that such a board is not meeting its community obligations by refusing to provide some means for the treatment of the sick, although such patients were suffering with an infectious or semicontagious condition.

The superintendent of this institution might have suggested some alternative for the care of these patients. The opening of an emergency hospital in a wing or isolated section of his plant, the establishment of emergency provisions elsewhere or the reference of elective surgery to other institutions are measures which might suggest themselves.

If, however, the board is obdurate in refusing to alter such a regulation, the only alternative which the executive possesses is to enforce it or else to resign. The evasion of the hospital authorities' rule by physicians in submitting a false diagnosis is both unethical and dishonest. A nonmedical superintendent, however, is at a complete disadvantage in detecting such a procedure. Should the administrator suspect that physicians were being guilty of bad faith, the matter should be reported to the board of trustees for investigation and action. If such a charge could be proved the resignation of the offending physician should be requested immediately.

### What Should Be Done When Staff Members Do Not Attend Monthly Conferences?

There is always not a little difficulty encountered when institutions for the first time organize monthly staff conferences. Physicians look upon this procedure as merely another thing to harass them and consume time which might be devoted to other matters that seem more important.

The answer to this question, which had its origin in a Southern hospital, lies along the line of prevention rather than of cure. When the staff conference is being organized the presiding officer should be carefully selected. He should be a man of force and vision, one who can perhaps be more or less professionally and financially independent so that he does not fear to require attendance upon these meetings. It should be understood from the start that the board of officers demands that the staff conferences be attended by all those concerned. A roll should be kept by the secretary showing those who are in attendance. A rule should exist that no staff member shall be absent without proper excuse. Even when these excuses seem adequate they should not be approved too frequently. A monthly report should be made by the secretary to the medical executive committee or a similar body. It may be said that this committee should require a frequent general statement from staff conferences relative to the attendance, the type of work performed as well as any routine measures that seem to be for the good of the hospital.

Should an individual miss two successive staff conferences without adequate excuse it would seem that after he has been notified by the presiding officer of the neces-

sity for attendance, his name should be presented to the medical executive committee and perhaps to the board of trustees itself for action. Attendance at these meetings should be as obligatory as faithful attendance upon ward patients. There can be no doubt as to the benefit the hospital receives as the result of these conferences. Should a staff member find it impossible to attend these meetings regularly, the board of trustees would be perfectly justified, it would appear, in inquiring as to whether he desires to be continued as a member of the visiting staff of the hospital.

### How Does Infection With the Gas Bacillus Take Place?

The *Bacillus aerogenes-capsulatus*, or the gas bacillus, is a deadly organism which, when once implanted beneath the skin of a patient, produces the presence of gas, the death of the tissues and finally that of the patient. In an Eastern institution two such infections took place following an ordinary hypodermic injection. One of these consisted of the subcutaneous administration of a form of digitalis and another of a biological product frequently used in the hospital. Both infections took place at the site of injection on the external surface of the patient's arm.

In such a tragic situation as this it behooved the hospital to leave no stone unturned to learn the cause of this accident and hence to prevent its recurrence in the future. The technique employed in the hypodermic administration of drugs in this institution had been carefully worked out. The needles and hypodermic syringes had been sterilized but, since both drugs were kept in bottles without rubber perforable caps, it was thought that the stock solution might have become infected. Careful culture of these solutions failed to reveal the evidence of gas bacilli. The skin had been sterilized with alcohol prior to puncture as is the custom and this technique as far as could be learned had been carefully followed. The stools of all patients in this ward, numbering twenty-five, were examined and in 85 per cent of the cases gas bacilli were found. It is the conjecture of the hospital administrator that in the case of these two patients, who were critically ill, somehow the infected contents of the intestinal tract had come in contact with the patient's skin and that the gas bacilli had been subcutaneously implanted in advance of the needle.

Careful inquiries by the executive of this institution brought forth the fact that other hospitals had experienced a similar disaster. The remedies would seem to comprise an attempt to improve hypodermic technique, the use of ampules or at least bottles with perforable rubber tops and perhaps the addition of a routinely wrapped and sterilized hypodermic set. When a 2 cc. glass syringe is routinely used for hypodermic purposes, if the hospital can purchase a sufficient number of these articles, it is an excellent plan never to use the syringe or needle a second time until it has been reesterilized by heat. It would appear also that much carelessness exists in sterilizing the skin. The use of mercurochrome or iodine followed by alcohol is an excellent if somewhat time consuming procedure. Too great care cannot be exercised in perfecting a proper hypodermic technique, since there is no other procedure that is more often practiced in the hospital than this. To remember the possibility of fecal soiling of the skin and the probability of the intestinal contents containing gas bacilli is to point to efficient and common sense methods of prevention.



## NEWS OF THE MONTH

# Fine Programs Feature of February Hospital Meetings

**W**HAT promises to be the most important health and hospital week of the year, with the exception of national meetings, has been planned for the week beginning on February 17, in Chicago.

At this time the following meetings will be held: the annual Congress on Medical Education, Licensure and Hospitals of the American Medical Association; a joint meeting of the Illinois, Wisconsin and Indiana Hospital Associations, with the Michigan Hospital Association participating as a guest; the meeting of the Central Council for Nursing Education; the twelfth annual convention of the National Methodist Hospitals, Homes and Deaconess Association; the American Conference on Hospital Service and the meeting of the Chicago Record Librarians. Many of these meetings will be held at the Palmer House, while others will be held at the Congress Hotel and at the University of Chicago.

Much of interest to all hospital administrators will be found on the program of the Congress on Medical Education, Licensure and Hospitals. It is expected that Ray Lyman Wilbur, Secretary of the Interior, will act as chairman of the meetings, and at the first session a paper entitled "Relation of Federal, State and Municipal Governments to Hospitals" will be given by Dr. William Gerry Morgan, Washington, D. C., president-elect of the American Medical Association. "The American Medical Association—Its Function and Future," will be the subject of an address by Dr. Morris Fishbein, editor, *Journal of the American Medical Association*, and Dr. Willard C. Rappleye, New Haven, Conn., director of study, Commission on Medical Education, will discuss "Current Problems in Medical Education."

### *Programs for Monday and Tuesday*

The following speakers will appear on the Monday afternoon program: Dr. Ernest E. Irons, Rush Medical College, Chicago, "The Selection of Proprietary *versus* Nonproprietary Drugs in Hospital Prescribing;" Dr. Torald Sollmann, Western Reserve University School of Medicine, Cleveland, "Evaluation of Therapeutic Remedies in the Hospital;" Dr. McKim Marriott, Washington University School of Medicine, St. Louis, "The Use of Proprietary and Medicinal Foods in the Hospital;" William Gray, pharmacist, Presbyterian Hospital, Chicago, "Staff Cooperation With the Hospital Pharmacist."

At one of the Monday afternoon sessions, the discussion will be given over to laboratory practices. Among the four papers of importance scheduled is one that will be of particular interest to hospital administrators, entitled "Educational Influence of Pathology on House Officers

in a Teaching Hospital," to be given by Dr. Howard T. Karsner, Western Reserve University School of Medicine, Cleveland.

Tuesday morning Dr. William Darrach, dean, Columbia University College of Physicians and Surgeons, New York City, will preside and medical teaching hospitals will be discussed. Dean Charles R. Bardeen, University of Wisconsin Medical School, will speak on "Medical Teaching Plants." Dr. G. Canby Robinson, New York City, will read a paper on "The Plans of the New York Hospital-Cornell Medical College Association." Paul H. Fesler, superintendent, University of Minnesota Hospital, Minneapolis, will discuss "Special Facilities Required for Teaching in Hospitals Affiliated With Medical Schools" and Dr. Charles B. Pinkham, Sacramento, Calif., will talk on "Fraudulent Credentials Submitted for Licensure."

### *Physical Therapy to Be Discussed*

The subject of physical therapy will occupy all of the Tuesday afternoon session, with the following speakers: Dr. Merritte W. Ireland, Surgeon-General, United States Army; Dr. Irving S. Cutter, dean, Northwestern University Medical School, Chicago; Dr. S. S. Goldwater, former director, Mt. Sinai Hospital, New York City, and Dr. John S. Coulter, assistant professor of physical therapy, Northwestern University Medical School.

The hospital administration and staff organization session will also be held on Tuesday morning. At that time Dr. Walter S. Goodale, superintendent, Buffalo City Hospital, will speak on "Hospital Administration;" Dr. Donald C. Smelzer, superintendent, Charles T. Miller Hospital, St. Paul, Minn., will discuss "Staff Organization," and E. I. Erickson, superintendent, Augustana Hospital, Chicago, will talk on "Staff Organization."

Other sessions will be given over to the hospital department of radiology; the Federation of State Medical Boards, Medical Licensure and Registration, the teaching of obstetrics and the training of technicians.

The program for the American Conference on Hospital Service will be presented on Tuesday. Dr. Harry E. Mock, Chicago, will preside. At the morning session Dr. Bert W. Caldwell, executive secretary, American Hospital Association, Chicago, will speak on "Hospitals and the Cost of Medical Care From the Viewpoint of the Hospital." Dr. James B. Herrick, Chicago, will discuss the same subject from the viewpoint of the hospital staff; Dr. Arthur T. Holbrook, Milwaukee, from the standpoint of the general practitioner, and Wilfred S. Reynolds, executive director, Chicago Council of Social Agencies, will discuss the subject from the standpoint of the layman.

## News of the Month

Dr. Ray Lyman Wilbur, Dr. L. L. McArthur, Chicago, Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Alfred C. Meyer, trustee, Michael Reese Hospital, Chicago, and Charles A. Wordell, manager, St. Luke's Hospital, Chicago, will take part in the discussion.

In the afternoon the subject of hospital provision for the Negro race will be the general theme. Dr. Peter M. Murray, New York City, will read a paper entitled "Hospital and Out-Patient Facilities for the Adequate Care of the Sick;" Dr. Basil C. H. Harvey, University of Chicago, will speak on "Providing Adequate Facilities for the Education of Colored Medical Students." Adda Eldredge, director of nursing education, State Board of Health, Madison, Wis., will discuss "The Need for a Sound Professional Preparation for Colored Nurses." There will also be a general discussion.

The joint meeting of the Illinois, Indiana and Wisconsin Hospital Associations will convene on Wednesday, February 18. The associations will hold separate meetings on the first day and will combine in a general program for the second and third days. It is expected that there will be present at this meeting alone approximately 500 hospital administrators and department heads, which, combined with those who will attend the other meetings, will make close to 700 hospital and medical people in Chicago.

On Wednesday Albert G. Hahn, president of the Indiana Hospital Association, will preside at the Indiana meeting for which a general program of legislation subjects has been worked out. In addition to one entire session given over to the discussion of state legislative problems at which time State Senator William F. Hodges, J. D. O'Meara, Fort Wayne, George William Wolfe, Lafayette, and Matthew O. Foley, editor, *Hospital Management*, will speak, another session will have as speakers V. I. Sandt, superintendent, Fairview Hospital, LaPorte; Mrs. G. M. Lake, superintendent, Home Hospital, Lafayette; L. Luella Cox, superintendent, Methodist Hospital, Gary, and Mary E. Thompson, superintendent, Methodist Hospital, Princeton.

The Illinois and Wisconsin meetings will be given over entirely to the discussion of legislative matters, a round table on practical problems and the business session.

### Joint Session Starts on Thursday

On Thursday morning the big session will commence with Dr. Donald M. Morrill, superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich., presiding. The first speaker will be Dr. Bert W. Caldwell, who will discuss "Four Major Problems in Hospital Administration." This will be followed by a paper on "The Absorption of Special Charges," by L. C. Austin, superintendent, Mt. Sinai Hospital, Milwaukee. "Endowment for Schools of Nurses" is the subject of Adda Eldredge's paper, and there will be a general discussion of all papers at the end of the session conducted by Dr. Robert C. Buerki, director, University of Wisconsin Hospital, Madison.

On Thursday afternoon, J. W. Meyer, Aurora, president of the Hospital Association of Illinois, will preside. The first speaker will be Veronica Miller, superintendent, Henry Hospital, Chicago, whose subject will be "The Superintendent's First Steps in Planning a New Hospital." Dr. Stewart Hamilton, director, Harper Hospital,

Detroit, will speak on "The Coordination of Departments" and John A. McNamara, executive editor, *THE MODERN HOSPITAL*, Chicago, will read a paper entitled, "The Functions of the State Hospital Association."

On Friday afternoon, Albert G. Hahn will preside and the following program will be given: "Staff and Departmental Meetings," Dr. Malcolm T. MacEachern, associate director, American College of Surgeons; "What a Hospital Trustee Should Know," Richard P. Borden, trustee, Union Hospital, Fall River, Mass.; "The X-Ray Film Situation," Dr. Charles E. Remy, superintendent, Montefiore Hospital, Pittsburgh. Robert E. Neff, administrator, Iowa University Hospitals, will direct the general discussion.

### Doctor Coon to Preside

Dr. John W. Coon, Steven's Point, Wis., president of the Wisconsin Hospital Association, will preside at the Friday afternoon session at which time the following topics will be discussed: "Emergency Work in the General Hospital," "The Hospital, a Center for Cooperative Community Social Work," "The Hospital Dietitian," and a general discussion by E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago.

On Thursday evening a banquet will be held with Dr. Christopher G. Parnall, president of the American Hospital Association, presiding and with several nationally known speakers on the program.

On Wednesday evening a session of the Cook County Hospital Librarians will be held at the Albert Merritt Billings Memorial Hospital, when there will be a demonstration of the unit recording system together with an inspection of the out-patient department and other points of interest in the hospital.

The twelfth annual convention of the National Methodist Hospitals, Homes and Deaconess Association will be held at the Congress Hotel on February 18 and 19. Dr. J. A. Diekmann, Cincinnati, president of the association, will preside and will be the first speaker with the topic "The High Cost of Sickness and Its Remedy." This will be followed by a report of the secretary, G. M. Hanner, superintendent, Beth-El Hospital, Colorado Springs, Colo., and the report of the treasurer, Dr. Bascom Robbins, executive secretary, Bethany Hospital, Kansas City, Kan.

On Tuesday afternoon group meetings will be held with E. S. Gilmore as chairman.

The program for these meetings is as follows "Present Day Dangerous Tendencies in Hospital Life," May Tompkins, superintendent, Methodist Hospital, Peoria, Ill.; "Anesthetics and Anesthetists," Dr. Ethel M. Laybourne, superintendent, Methodist Hospital, Freeport, Ill.; "The Intern Problem," Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland; "The Hospital Laboratory," J. Fred King, superintendent, Methodist Hospital, Joplin, Mo.; "The Importance of Hospital Atmosphere," Rev. Carol Lewis, executive secretary, Christ Hospital, Cincinnati; "The Value of Criticism to the Hospital," Dr. George M. Smith, superintendent, Methodist Hospitals of Indiana, Indianapolis.

At the annual banquet to be held in the evening, an address will be given by Bishop H. Lester Smith, Chattanooga, Tenn.

On Wednesday morning there will be a debate on the



## News of the Month

subject: Resolved, That the Institutional Building, Its Finances, Equipment and Apparatus Are Greater Factors Than the Personnel." The affirmative will be upheld by Rev. Luther Reynolds, superintendent, Seattle General Hospital, Seattle, Wash., and the negative by Dr. J. R. Heath, superintendent, Bethany Hospital, Kansas City, Kan.

"Annuities" will be the subject of the paper read by Dr. Dwight S. Ritter, chairman of the Committee on Annuities From the World Service Commission. The last subject at this session will be "Present Day Problems and Tendencies in Schools of Nursing." This will be discussed from the standpoint of the hospital administrator by Dr. Charles Cole, superintendent, Sibley Hospital, Washington, D. C., and from the viewpoint of the nurse by Bertha Knapp, superintendent of nurses, Wesley Hospital, Chicago.

Reports and business will occupy the closing session.

The program of the Central Council for Nursing Education is as follows: "Education of the Nurse From the Point of View of Public Health Nursing," by Edna L. Foley, Visiting Nurse Association, Chicago; "The Value of Experience in Hospital Social Service to the Student Nurse," by Ruth Emerson, director, social service department, University Clinics, University of Chicago; "The University and Nursing Education," by Clarence S. Yoakum, Northwestern University, Chicago; "Nursing and the Community," by Dr. Haven Emerson, professor of public health administration, Columbia University, New York City; "Economic Aspects of Nursing Education and Nursing Service From the Point of View of the Hospital Executive," by Dr. Christopher G. Parnall, president of the American Hospital Association. An address will be given by Edwin R. Embree, president of the Julius Rosenwald Fund, Chicago.

At the dinner in the evening Dr. Robert Maynard Hutchins, president of the University of Chicago, will be the speaker.

### Plans Completed for Guggenheim Dental Clinic

Preliminary plans for the establishment of a six-story dental clinic, equipped to give 200,000 dental treatments a year to New York's children, were completed recently, according to the *New York Times*.

The new building will accommodate seventy dental chairs and is planned for expansion. It will be the central unit in the Murry and Leonie Guggenheim Dental Clinic, which will conduct an extensive program of dental prophylaxis among the city's school children. This clinic, the gift of Mr. and Mrs. Murry Guggenheim, New York, was organized with the expectation that it will eventually establish a series of dental clinics over the country.

On the first floor of the new building will be a large entrance hall, a bureau of registration, a social service office, rooms for preliminary examinations and classification of patients, a check room for children's coats and a rest room for social workers and visiting school teachers.

The two upper floors of the building will be occupied by the principal operative clinics. Separate floors will be

assigned to a school for oral hygienists, a department for oral surgery and a department for orthodontia. Other features of the building include an x-ray room, a biologic and histologic laboratory, a room for photography, a library, a board room, a lecture room and a dental museum.

### Doctor Haviland Dies in Egypt

Dr. C. Floyd Haviland, superintendent, Manhattan State Hospital, Ward's Island, N. Y., died January 1 at Cairo, Egypt, as a result of pneumonia.

Doctor Haviland was fifty-five years of age and was a well known psychiatrist. Before assuming the directorship of Manhattan State Hospital he had been connected

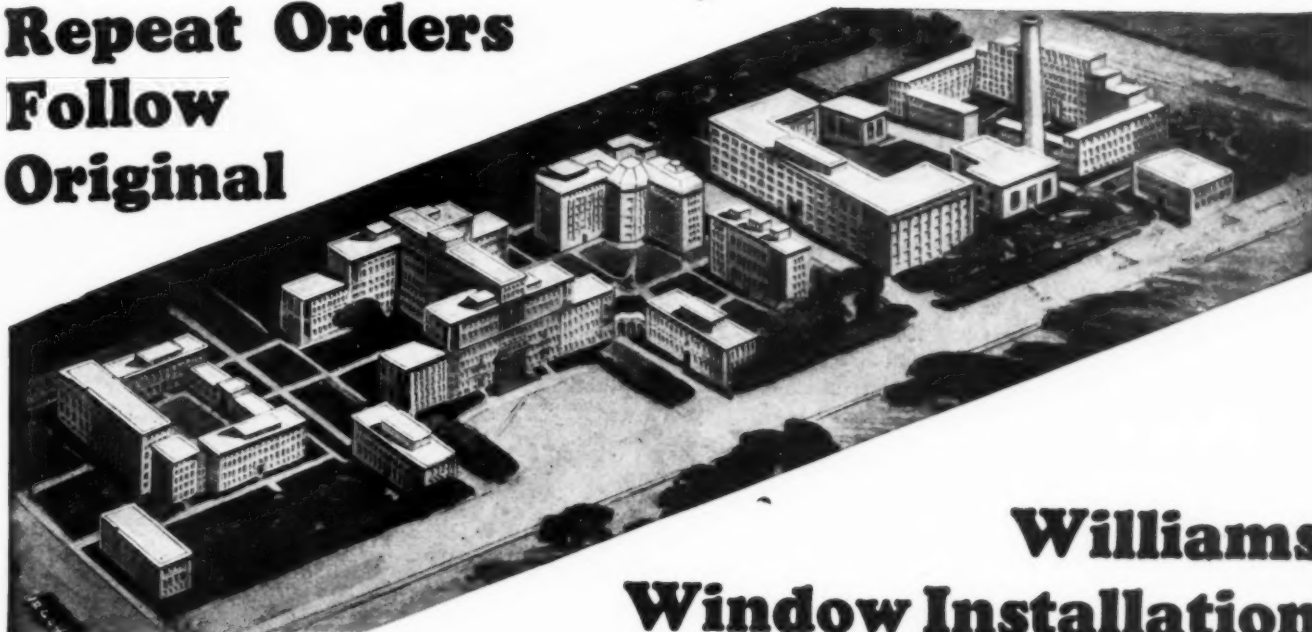


in various capacities with the King's Park State Hospital, King's Park, N. Y., and with the Connecticut State Hospital, Middletown, Conn., and from 1921 to 1926 he was chairman of the New York State Hospital Commission. In 1914 he made a survey of the care of the insane in Pennsylvania, at the request of the National Committee for Mental Hygiene. He was deeply interested in occupational therapy and was president of the American Occupational Therapy Association.

Doctor Haviland was a frequent contributor to psychiatric journals and was a member of the editorial board of *THE MODERN HOSPITAL*.

Doctor Haviland's father is Dr. Norman H. Haviland, who is engaged in medical practice at Fulton, N. Y., and his brother, Dr. Ross Haviland, is assistant superintendent, State Hospital for the Insane, Brooklyn.

## Repeat Orders Follow Original



## Williams Window Installation

**W**ILLIAMS Reversible Window Equipment has been specified and installed in six buildings of the great University Hospital Group in Cleveland. The first installations beginning in 1926 were in the Maternity Hospital, the Babies and Children's Hospital and the Institute of Pathology, all designed by Architect Abram Garfield, of Cleveland.

Construction is now under way on the new Lakeside Hospital, the Nurses Dormitory and the Private Pavilion designed by Architects Coolidge, Shepley, Bulfinch & Abbott of Boston. The satisfaction given by the equipment installed in the earlier buildings, was the deciding factor in its selection for the later units. The entire project will have almost 3000 Williams equipped windows.

This equipment is thoroughly established in the hospital field having been used for many years in large and small hospitals throughout the country. In 1929 alone 20 new hospitals have ordered equipment for more than 9000 windows.

Hospital authorities and architects regard Williams Reversible Window Equipment as ideal for hospitals because it reduces window cleaning costs and improves ventilation. Williams Reversible Windows are reversed so that both sides of the glass are cleaned from inside the room without annoyance to patients. This saves from  $33\frac{1}{3}$  to 50% of the time required to clean ordinary windows.

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## News of the Month

### Chicago Dietetic Association Elects New Officers

The Chicago Dietetic Association held its monthly meeting on January 15. An interesting program was provided for the members. H. W. Pasko, Chicago, of the scientific department of a firm of manufacturing chemists, showed a moving picture demonstrating how insulin is produced. Dr. I. Harrison Tumpeer, a member of the staff of the Michael Reese Hospital, Chicago, spoke on "Food Allergies."

The association has elected the following officers for the coming year: Millie Kalsem, Cook County Hospital, president; Sarah Elkin, Mandel Clinic, Michael Reese Hospital, vice-president; Elsbeth Hennecke, Presbyterian Hospital, secretary, and Lida Jamison, Presbyterian Hospital, treasurer.

### Doctor Rees Heads Colorado Hospital Association

Members of the Colorado Hospital Association gathered at Denver for their annual meeting in December.

The following officers for the coming year were elected: Dr. Maurice H. Rees, University of Colorado School of Medicine and Hospitals, Denver, president; Dr. H. A. Green, Boulder-Colorado Sanitarium, Boulder, first vice-president; Mrs. Oca Cushman, Children's Hospital, Denver, second vice-president; Mrs. Bessie K. Haskin, Denver General Hospital, Denver, treasurer; Frank J. Walter, St. Luke's Hospital, Denver, secretary.

The program of the meeting was divided into four sections. The Colorado Dietetic Association, the Social Service Workers Association and the Colorado State Nurses' Association assisted in planning the sectional programs.

In the administrative section, papers were given on: "Organization of the Hospital Staff;" "Intern Problems;" "The Hospital X-Ray Department;" "Colorado Law Pertaining to Hospitals;" "The Hospital's Duty in Furnishing Information to Insurance Companies in Liability and Compensation Cases," and "Hospital Accounting."

The dietetic sectional program consisted of papers on the following subjects: "The Routine Hospital Diet From the Standpoint of the Physician;" "The Rise of the Glorified Cook;" "The Dietitian and the Physician;" "The Dietitian and the Superintendent;" "The Dietitian and the Nursing Staff," and "The Administrative Dietitian."

### Chicago Visiting Nurse Association Holds Fortieth Annual Meeting

The Visiting Nurse Association of Chicago held its fortieth annual session on January 22, at the Blackstone Hotel, Chicago.

The program given consisted largely of reports by the various officers and committees of the association. The president's report was presented by Margaret B. Conover;

that of the nurses' committee by Mrs. Edgar B. Goodspeed; that of the committee on after care and the study of infantile paralysis by Mrs. Albert A. Sprague; the treasurer's report by Mrs. George E. Throop; the report of the auxiliary committee by Mrs. Ralph T. Winston and the superintendent's report by Edna L. Foley.

Pictures taken of the patients in the districts visited by the nurses were shown by Mrs. Uri B. Grannis, recording secretary.

Officers and directors for the coming year were elected.

### Coming Meetings

#### American Hospital Association.

President, Dr. Christopher G. Parnall, Rochester General Hospital, Rochester, N. Y.  
Executive secretary, Dr. Bert W. Caldwell, 18 E. Division St., Chicago.

Next meeting, New Orleans, October 20-24.

#### American Medical Association.

President, Dr. M. L. Harris, 25 E. Washington Street, Chicago.  
Secretary, Dr. Olin West, 535 No. Dearborn Street, Chicago.

Next meeting, Detroit, June 23-27.

#### American Nurses' Association.

President, S. Lillian Clayton, Philadelphia General Hospital, Philadelphia.  
Secretary, Susan C. Francis, Children's Hospital, Philadelphia.

Next meeting, Milwaukee, June 9-14.

#### American Occupational Therapy Association.

Vice-president, Dr. B. W. Carr, Washington, D. C.  
Secretary-treasurer, Mrs. Eleanor Clarke Slagle, 175 Fifth Ave., New York City.

Next meeting, New Orleans, October 20-24.

#### American Protestant Hospital Association.

President, Luther G. Reynolds, Seattle General Hospital, Seattle, Wash.  
Executive secretary, Dr. Frank C. English, Hyde Park Station O., Cincinnati.

Next meeting, New Orleans, October 17-20.

#### American Society of Clinical Pathologists.

President, Dr. J. H. Black, Dallas, Texas.  
Secretary-treasurer, Dr. H. J. Corper, Metropolitan Bldg., Denver, Colo.

Next meeting, Detroit, June 20-23.

#### Annual Congress on Medical Education, Medical Licensure and Hospitals.

Next meeting, Chicago, February 17-19.

#### Children's Hospital Association of America.

President, Dr. Howard Childs Carpenter, 1805 Spruce St., Philadelphia.  
Secretary-treasurer, Bena M. Henderson, Milwaukee Children's Hospital, Milwaukee.

Next meeting, New Orleans, October 20-24.

#### National League of Nursing Education.

President, Elizabeth C. Burgess, Columbia University, New York City.  
Secretary, Nina D. Gage, 370 Seventh Avenue, New York City.

Next meeting, Milwaukee, June 9-14.

#### National Methodist Hospitals, Homes and Deaconess Work Association.

President, Dr. J. A. Diekmann, Bethesda Hospital, Cincinnati.  
Secretary, Guy M. Hanner, Beth-El General Hospital, Colorado Springs, Colo.

Next meeting, Chicago, February 18-19.

#### Hospital Association of the State of Illinois.

President, J. W. Meyer, Aurora Hospital, Aurora.  
Secretary, E. I. Erickson, Augustana Hospital, Chicago.

Next meeting, Chicago, February 19-21.

#### Indiana Hospital Association.

President, Albert G. Hahn, Deaconess Hospital, Evansville.  
Secretary, Gladys Brandt, Cass County Hospital, Logansport.

Next meeting, Chicago, February 19-21.

#### Iowa Hospital Association.

President, Robert E. Neff, University Hospital, Iowa City.  
Secretary, Harold A. Grimm, The Finley Hospital, Dubuque.

Next meeting, Waterloo, February 27-28.

#### Hospital Association of Pennsylvania.

President, Elizabeth H. Shaw, St. Margaret's Memorial Hospital, Pittsburgh.  
Secretary, Howard E. Bishop, Robert Packer Hospital, Sayre.

Next meeting, Pittsburgh, March 25-27.

#### Wisconsin Hospital Association.

President, Dr. J. W. Coon, River Pines Cottage Sanatorium, Stevens Point.  
Executive secretary, L. C. Austin, Mt. Sinai Hospital, Milwaukee.

Next meeting, Chicago, February 19-21.

# A Humane and Highly Important Work



## The Service:

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Watchman's service.

Proper handling of special hazards such as anaesthetical apparatus; the storage and use of inflammable and explosive oils and gases, volatile liquids, paints and chemicals.

X-Ray films.

As evidence of the desire to cooperate with hospital authorities in the extension of fire prevention and protection, the Stock Fire Insurance companies, through the National Board of Fire Underwriters, adopted a resolution offering to all hospitals throughout the country the services of the National Board and its engineering force to aid trustees and other hospital officials in developing plans for the saving of life and property from fire, explosions and other hazards.

Particularly was this service extended to the leading hospital associations, each of which was invited "to appoint a committee from the membership of which a joint representative committee may be selected for general cooperation with the National Board in the humane and highly important work referred to."

The inspection organization maintained by the Stock Fire Insurance companies in your state is prepared to render this service. If you are not familiar with the name and location of that organization, write to the address below. You will also receive a copy of "Fire Prevention and Protection as Applied to Hospitals."



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## News of the Month

### New York Infirmary to Raise Funds for New Building

The New York Infirmary for Women and Children, New York, the first hospital in the United States to specialize in its field, will conduct a campaign to raise \$3,000,000 to replace its obsolete buildings with a twelve-story skyscraper.

The infirmary was founded seventy-five years ago by Dr. Elizabeth Blackwell, the first woman to take a doctor's degree in the United States, according to a recent issue of the *Survey*.

### Philadelphia Chapter of Record Librarians Meets

The Philadelphia chapter of the Association of Record Librarians of North America met January 10, in Philadelphia at the Graduate Hospital. Irene Johnson, Graduate Hospital, is president of the chapter; Mary Jobes, Woman's Hospital, vice-president, and Margaret Casey, Stetson Hospital, secretary-treasurer.

The most important topic discussed at the meeting was "Is the Insurance Company (Life, Liability, or Compensation Carrier) Entitled to Get or the Hospital to Give All Data Asked for From Hospital Record Books?" The viewpoint of the insurance company was presented by Herbert W. J. Hargrave, manager, claim department, National Bureau of Casualty and Surety Underwriters, New York City. Clement Biddle Wood, Philadelphia, discussed the subject from the standpoint of the law, while Dr. Thomas McKean Downs, Philadelphia, gave the hospital's view of the situation.

### Chicago to Have Negro Medical Center

A campaign to provide a \$3,000,000 medical center for Negroes was launched on January 14 by the Provident Hospital and Training School, Chicago, in cooperation with the University of Chicago. The plan is to provide a modern training school for Negro medical students and a modern hospital for Negroes in America.

The death rate for Negroes in Chicago has been lamentably high, higher even than the general death rate in Calcutta, despite the fact that Chicago's general death rate is one of the lowest in the world and Calcutta's one of the highest. This has been due mainly to the fact that there have been no adequate facilities for the training of Negro doctors and Negro nurses.

The minimum amount needed is \$3,000,000. Of that sum \$1,000,000 is required by the University of Chicago as a teaching and research fund. This has already been subscribed to the university by John D. Rockefeller through the General Education Board.

The remaining \$2,000,000 is needed by the Provident Hospital and Training School, of which \$750,000 has been subscribed through the Julius Rosenwald Fund and other

groups. Of the remaining \$1,250,000, to be raised in the general campaign, gifts of \$100,000 each have been received from two wealthy Chicagoans.

The \$2,000,000 required by Provident Hospital will be utilized as follows: \$900,000 for the housing of the prospective new Provident Hospital and Training School, \$750,000 of which will be used to acquire the present plant of the Chicago Lying-In Hospital and \$150,000 to remodel and provide the equipment. The remaining \$1,100,000 is the minimum required for the operating fund for the institution.

The Negroes of Chicago and of the nation are planning to do their share in raising the money, but by far the greater part of the sum needed for the project must come from white people.

The program of the Provident Hospital, with the cooperation of the University of Chicago, will make possible high grade care of Negro sick, instructions for Negro medical students, especially postgraduates, an increased number of internships for Negro doctors and opportunity for research on diseases that present the gravest problems for the Negro race.

### Deutsche Hygiene Museum to Open in Dresden

The Deutsche Hygiene Museum, Dresden, will move into its new home in the Spring. This central institution for public hygiene has developed active connections with almost all of the civilized countries of the world, and the cultural work done by it has helped in picking up the threads with foreign countries that had been torn by the war.

Professor Dr. Kreis has been in charge of the construction of the building. The plans provide for well lighted corridors running through the whole building. The workshops will be in the basement; the bookshelves, laboratories, gymnasium and storerooms in the left wing and the depots and packing rooms in the main building. The museum rooms proper will be on the upper floor, together with lecture rooms and study rooms.

### Evanston Plans Hospital for Its Negro Colony

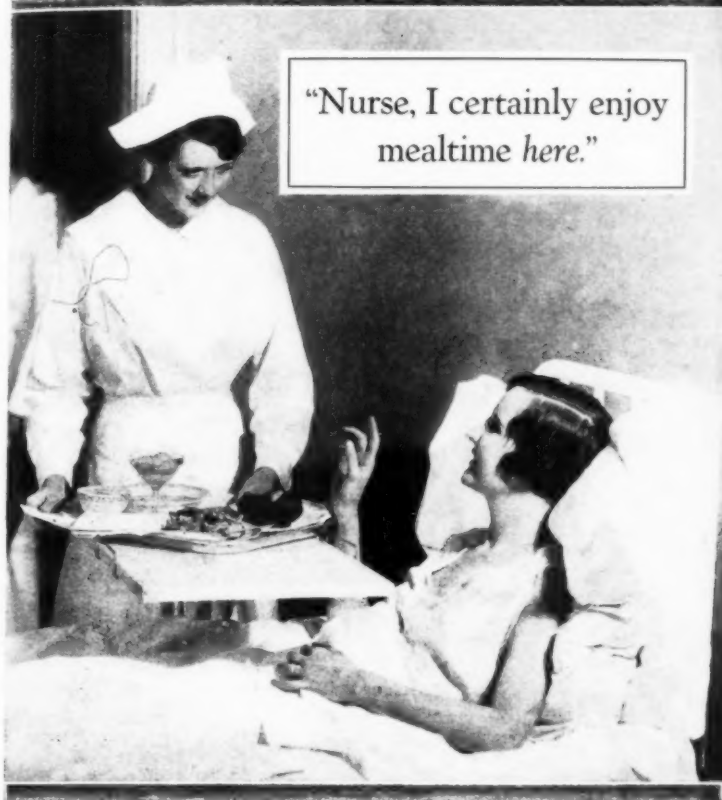
In line with the recent campaign for funds for a Negro hospital and training school for doctors and nurses in Chicago, Evanston, Ill., has made plans for a hospital to provide for its large Negro colony.

A house has been leased, the necessary alterations being made, and it is planned to open the hospital about the middle of February.

A widespread campaign for funds will not be conducted at the present time, but various citizens of Evanston have promised their aid to the project.

Dr. Garnett Butler, who with her husband has devoted her time to working with her people, has been selected as superintendent of the new hospital, according to a statement appearing in the *Chicago Tribune*.





## HOT MEALS

**T**ODAY—convalescent patients are keen mealtime critics. They expect good service—good food served **HOT!** Food service has, therefore, become the most important non-medical function performed by the hospital staff.

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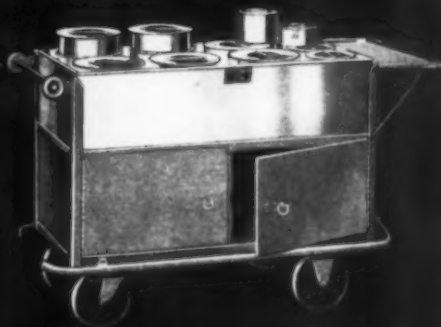
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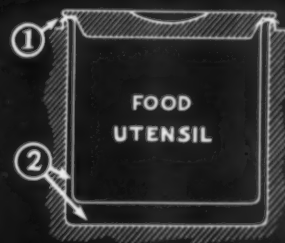
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# Ideal

## FOOD CONVEYOR SYSTEMS

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## News of the Month

### \$371,378,000 to Go for Hospitals This Year

Valuation of new hospital construction during 1930 is estimated at \$371,378,000 by C. Stanley Taylor, director of research for the National Trade Journals, Inc., publishers of the *Architectural Forum*. This figure is an increase of \$118,851,000 over the hospital building forecast for 1929, which totaled \$252,527,000.

Changes in the demand for new hospital buildings in the chief geographic districts of the nation are shown in the following tabulation of percentages of total construction for all classes of buildings:

Geographic District	1929 Forecast	1930 Forecast	Change
North Atlantic States.....	5.6%	9.6%	+4.0
Northeastern States .....	7.1%	8.3%	+1.2
Southeastern States .....	3.3%	5.4%	+2.1
Middle States .....	4.1%	5.8%	+1.7
Western States .....	5.6%	3.9%	-1.7
Southwestern States .....	3.5%	9.6%	+6.1
37 States East of Rockies...	4.9%	7.4%	+2.5

Accuracy of the forecasts in the entire building field is apparent from a comparison of the 1929 forecast with the actual contracts awarded in the same year. The forecast for 1929 was \$5,116,773,200; the contracts actually awarded during 1929 totaled \$5,754,290,500, for all types of buildings.

Hospitals now occupy fifth place in the general building market of the country. The special fields and their percentage ratios to the total building program, ranged by size, are as follows: office buildings, 13.5 per cent; schools, 12.8 per cent; apartments, 10.9 per cent; hotels, 7.8 per cent; hospitals, 7.4 per cent; public buildings, 6.3 per cent; industrial, 5.7 per cent; churches, 4.3 per cent; apartment hotels, 4.2 per cent; automotive, 3.4 per cent; stores, 3.3 per cent; clubs, 3.2 per cent; dwellings (\$20,000 to \$50,000), 2.7 per cent; welfare, 2.8 per cent; banks, 2.7 per cent; dwellings (below \$20,000), 2.7 per cent; dwellings (over \$50,000), 2.3 per cent; theaters, 1.9 per cent; community buildings, 1.8 per cent.

### A Contest That Should Interest Nurses Everywhere

To the nurse, either student or graduate, who writes the best historical essay dealing with a nursing subject before January 1, 1931, there will be given an award of \$100. This award is to be known as the Adelaide Nutting-Lavinia Dock Prize in honor of these two pioneer writers of nursing history.

The conditions are: The subject must be one that is directly concerned with some important phase of nursing history; the essay must show original research; the essay should cover from 8,000 to 10,000 words and should be typewritten; there should be a cover page with the full title, a table of contents and a brief outline of the subject matter of the essay; the essay should be fully documented with footnotes and should include a detailed bibliography; the language used should be English, French or German.

The judges will make their decision on the basis of the worth of the material, the sources consulted, the form of the paper and the clarity and originality of the presentation.

The nurse who wishes to enter the contest should write to the chairman of the History of Nursing Committee, Nina Gage, 370 Seventh Avenue, New York City, giving her name, address, professional training and experience, and two references. She will then receive instructions.

### Indiana University Organizes Child Guidance Clinic

Indiana University has organized a clinic that will care for the children in the hospitals of the university who need psychiatric treatment and for children brought by their parents or referred by social agencies, courts, schools and physicians.

This clinic was instituted as a result of the demonstration clinic conducted in Indianapolis by the Commonwealth Fund and the National Committee for Mental Hygiene, New York City. It will be connected with various departments of the university of special services, and students will be able to obtain through it instruction in the theory and practice of mental hygiene and psychiatry, according to the *World's Children*.

### Ohio Hospitals Build Vaults for X-Ray Films

Three hospitals in Ohio have notified the state division of safety and hygiene that they are erecting fireproof vaults for storage of x-ray films, the safety director of the division, H. G. Ehret, recently announced. These hospitals are the City Hospital, Bellaire; the Central Clinic Hospital, Salem, and Mount Carmel Hospital, Columbus. Similar vaults are being built at Western Reserve University and the National Laboratories Co., Lorain.

The type of vault approved by the safety director may be built on the roof or may be located inside the building on condition the brick or tile walls of the vault are bonded in the brick of the exterior wall.

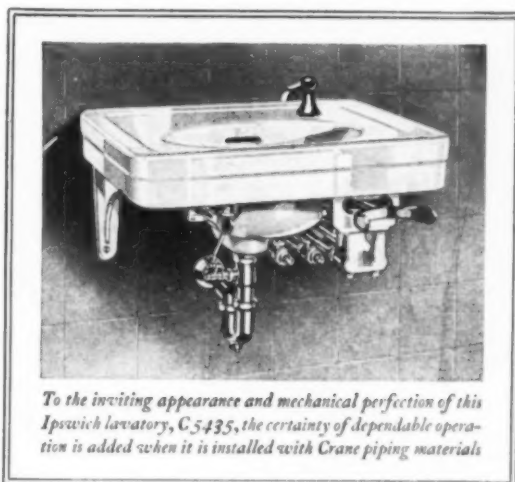
Other provisions include the use of incombustible material for shelves, films to be stored in vertical position in containers, automatic deluge systems of unsealed sprinklers which react to a rising temperature, and fixed, marine type wiring.

### Doctor Wipperman Dies

Dr. Paul Wipperman, superintendent, Touro Infirmary, New Orleans, died January 2, after a month of serious illness caused by a rare form of blood poisoning in regard to which he had carried on extensive research. Before going to New Orleans Doctor Wipperman was for several years superintendent of the Decatur and Macon County Hospital, Decatur, Ill.

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## News of the Month

### Reading Hospital Will Have New Nurses' Home

Reading Hospital, Reading, Pa., announces that a sum sufficient to build and furnish a nurses' home was recently received by the hospital from anonymous donors. Approximately \$400,000 will be spent on the new building.

The structure will be of brick, matching the Colonial-Georgian architecture of the hospital. Each of the 116 rooms will have an individual bathroom, and will accommodate two nurses. The entrance to the rooms will be through a vestibule in which there will be a clothes closet for each nurse. The building will accommodate 232 nurses. Provision has been made for a comfortable sitting room on each floor. There will be three large open porches on each floor. A complete interhouse telephone service with a phone in every room and outside connections on each floor will be installed.

The new nurses' home is intended solely for living purposes and does not provide educational and recreational facilities, which will be provided for in a separate building.

### Illinois Nurses Send Out SOS

The Illinois State Nursing Association is preparing to write a history of nursing in Illinois. In this connection, the association has sent out the following S O S:

"Illinois Nurses—Anywhere—Everywhere:

"The Illinois State Nurses Association is preparing to write a history of nursing in Illinois. To accomplish this we are asking all Illinois nurses wherever they are to send us all the material they can obtain on the subject. It may include publications, reports, pictures, anecdotes by word of mouth, personal experiences and—What Have You?

"In every case the source of information should be given.

"A contest is being inaugurated with substantial prizes ranging from \$100 to \$5 to those sending in the most comprehensive and worthwhile collection.

"To all sending material of value it is hoped some remuneration may be given. Send material to the secretary, Mrs. Lucy Van Frank, Room 1504, 116 South Michigan Avenue, Chicago, who will give further details of the contest if desired."

### Dean of Yale School of Nursing to Study in the Orient

Annie W. Goodrich, dean of the Yale School of Nursing, has been invited by the Rockefeller Foundation to make a study of nursing conditions in the Orient in company with Mary Beard, assistant director of medical sciences for the foundation. Dean Goodrich and Miss Beard sailed January 11 from Vancouver on the *Empress of Asia*. They will first visit Peiping Union Medical College, Peiping, China, and St. Luke's International Hospital, Tokyo.

Chief among the problems that Dean Goodrich and Miss

Beard will investigate is the public health movement in the Orient, especially in its relations to graduate and undergraduate instruction for nurses.

A three months' leave of absence has been granted Dean Goodrich, who has been at the head of the Yale School of Nursing since it was founded in 1923. The Rockefeller Foundation recently gave \$1,000,000 toward the endowment of the school in recognition of its efforts to raise the standards of nursing education.

### New York State Psychiatric Institute Opened

New York State's new \$2,000,000 Psychiatric Institute and Hospital, a unit of the medical center at Broadway and One Hundred and Sixty-Eighth Street, New York City, was recently dedicated and opened to the public.

The tower of the new structure is occupied by laboratories for research; the twelfth floor by the library and museum, and the tenth and eleventh floors by the outpatient department; from the fourth to the ninth floors are rooms and wards. On the second and third floors are rooms for the personnel.

According to a statement in the *Journal of the American Medical Association*, the staff of the institute will include seventy-nine nurses and attendants in the wards, five psychiatrists, research associates and assistants in psychiatry, chemistry, bacteriology, internal medicine, psychology, occupational therapy and social service.

### Cuban Hospital Association Organized

The Cuban Hospital Association was organized on December 18, at a meeting held in Havana, according to Dr. Lopez Silvero. About one hundred delegates were present at the organization meeting.

### Essex County Spends Large Sum for Hospitals

Extensive building and planning for the sick marked the year 1929 for Essex County, N. J. A total of \$10,805,000 is represented in capital outlay for buildings completed or started during the year. Four hospitals have been finished, two of them now being occupied, at a total cost of \$3,775,000.

The new buildings include a nurses' home for the Babies' Hospital, Coit Memorial, Newark; a new main building at Orange Memorial Hospital, Orange; a new wing at Montclair Community Hospital, Montclair, and a new wing at Presbyterian Hospital, Newark, which opened in January.

Essex County is now constructing buildings at Essex Mountain Sanatorium, Verona, and at the Isolation Hospital and both Newark Memorial and Mountainside Hospitals have started building operations.



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## Personals

DR. J. G. PETTIT, superintendent, State Tuberculosis Sanitarium, Hopemount, W. Va., died recently.

WALTER E. WRIGHT, superintendent, Memorial Hospital, Pawtucket, R. I., since last March, has been reappointed for the ensuing year.

JULIA G. ANDERSON has resigned the superintendency of Englewood Isolation Hospital, Bridgeport, Conn.

JACK GUMPERT, aged 43, prominent in Jewish charity circles, died recently at his home in Brooklyn. MR. GUMPERT was a member of the board of directors of the Brooklyn Federation of Jewish Charities and had managed several of the organization's campaigns for funds. He was a director of the Hebrew Orphan Asylum.

MAXWELL LEWIS, assistant director, Beth Moses Hospital, Brooklyn, N. Y., has been appointed business manager of Sydenham Hospital, New York City.

DR. R. P. HARRIS has resigned as superintendent of the Pulaski County Hospital, Little Rock, Ark. He will be succeeded by DR. M. P. MCNEIL.

C. A. SHARKEY was recently appointed superintendent of the Citizens' Hospital, Barberton, Ohio. During the past four years, MR. SHARKEY has served as credit manager and welfare officer of Hamot Hospital, Erie, Pa.

HILDA E. HAYES has tendered her resignation as superintendent of Morton F. Plant Hospital, Clearwater, Fla. MISS HAYES will be succeeded by CICELY AMBLER, a graduate of the Rochester General Hospital, Rochester, N. Y.

DR. LEWIS S. JORDAN is the new superintendent of Riverside Sanatorium, Granite Falls, Minn. DOCTOR JORDAN was formerly assistant superintendent at Southwestern Minnesota Sanatorium, Worthington, Minn.

MARY E. SKEOCH is the new superintendent at St. Luke's Hospital, Marquette, Mich.

C. A. LINDBLAD, superintendent, Millard Fillmore Hospital, Buffalo, N. Y., has accepted the directorship of the Homeopathic Hospital, Providence, R. I., succeeding JAMES R. MAYS, resigned.

DR. ARCHIBALD G. FLETCHER, superintendent of the Leper Hospital of the American Mission at Taiku, Korea, has been awarded the blue ribbon decoration of the emperor of Japan in consideration of his twenty years work among the lepers.

DR. RUSSELL H. KANABLE has been appointed superintendent and medical director of the Wyoming State Tuberculosis Sanatorium, Basin, Wyo.

MARY S. POWER, R.N., was recently appointed director of the Official Registry for Nurses of the New York Counties Registered Nurses' Association. MISS POWER, a graduate of the Massachusetts General Hospital School of Nursing, has been head nurse at the University of Michigan Hospital, assistant superintendent of nurses, University of California Hospital, and assistant superintendent of nurses, Lakeside Hospital, Cleveland and superintendent of nurses, Harper Hospital, Detroit.

DR. GEORGE F. INCH was recently appointed by the Michigan State Hospital Commission as the medical superintendent of the state hospital to be erected at Ypsilanti, Mich. DR. PHILIP SHEETS will succeed DOCTOR INCH as superintendent of the state hospital at Traverse City, Mich. DOCTOR SHEETS was assistant at the Traverse City institution.

LOLA PHELPS, formerly associated with the Cleveland Clinic, Cleveland, will be chief executive of the new City Hospital, Fostoria, Ohio.

RHODA BARKER will succeed MISS M. M. DAILY as superintendent of Twin City Hospital, Dennison, Ohio. MISS BARKER has been a nurse at the hospital for some time.

DR. H. T. SUMMERSGILL has resigned as superintendent of Ball Memorial Hospital, Muncie, Ind. DOCTOR SUMMERSGILL came to Muncie a year ago to open the new hospital.

MABEL BINNER, who resigned as director of the dispensary and social service departments of the Children's Memorial Hospital, Chicago, in May, 1929, to take up postgraduate work, has recently been appointed superintendent of the hospital.

MISS F. SMUTNEY has accepted the superintendency of St. Margaret's Hospital, Kansas City, Kan.

DR. MARGARET H. SMYTH has recently been appointed to head the California State Hospital, Sacramento. DOCTOR SMYTH is the first woman to head a California state hospital. She succeeds the late DR. FRED. P. CLARK.

MICHAEL J. MCCORMICK, superintendent of the Isolation Hospital, Hoffman's Island, New York, for the past six years, died recently.

C. I. FULLER is the new superintendent at Maimonides Hospital, Liberty, N. Y.

LUCY CALHOUN was recently appointed to the superintendency of the Yuba City Hospital, Yuba City, Calif.

DR. E. T. OLSEN, superintendent, Detroit Receiving Hospital, Detroit, has recently been appointed honorary medical representative of Cuba in Michigan, according to an announcement made by GESAR A. BARRANCO, Cuban consul in Detroit.

JOHN SEXTON, Chicago, well known to hospital superintendents throughout the United States and a generous contributor to many charitable organizations, died January 15 at Los Angeles, after a three-day illness, as a result of pneumonia. Mr. Sexton was seventy-one years of age. Among the surviving members of his family is his son, SHERMAN J. SEXTON, who is also well known to hospital superintendents.

DR. J. WILLIAM GREEFF was recently named by Mayor Walker of New York City as commissioner of hospitals, to succeed DR. WILLIAM SCHROEDER, who has been made chairman of the new Sanitation Commission.

JESSE H. GRIESEMER, for six years assistant to the superintendent at the Allentown, Pa., Hospital, resigned recently to accept the superintendency of the new hospital at Quakertown, Pa.

JULIA MAY LEACH, R.N., has resigned as superintendent of the Halifax District Hospital, Daytona Beach, Fla.





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Cleveland, Ohio	
Detroit, Mich.	
Grand Rapids, Mich.	
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## News of the Month

### Hospitals Are Among Thirty-Three Worthiest Charities in U. S.

The thirty-three charitable institutions regarded as the most worthy in the United States in the opinion of former President Calvin Coolidge, former Governor Alfred E. Smith and Julius Rosenwald, noted Chicago philanthropist, were recently announced. These three men acted as a committee to select the beneficiaries of the \$6,000,000 residuary estate of the late Conrad Hubert, inventor of the flashlight.

The institutions receiving bequests have been divided into three classifications: those that will receive immediate amounts from the cash on hand; those that will share in the first \$1,000,000 realized from the unliquidated portion of the estate, and those that will share in the remainder of the estate when it is finally liquidated.

Among the institutions receiving money immediately from the cash on hand are the following hospitals: St. Vincent's Hospital, New York City, \$500,000; Provident Hospital, Chicago, \$500,000; Beekman Street Hospital, New York City, \$500,000, and the New York Foundling Hospital, \$50,000.

Beth Israel Hospital Association, New York City, will receive \$200,000 from the first \$1,000,000 realized from the further liquidation of the estate. The amount will be used in connection with the completion of its hospital building.

### Ontario Hospital Association Has New Offices

The Ontario Hospital Association is now located in the Medical Arts Building, Bloor and St. George Streets, Toronto.

The association is planning to hold its 1930 convention on October 1, 2 and 3 in Toronto. Exhibits of hospital equipment and supplies will again be a feature of the meeting.

### President Signs \$15,950,000 Veterans' Bill

On December 23, President Hoover signed a bill authorizing construction of veterans' hospital facilities to cost \$15,950,000.

An increase of 4,491 beds is provided for in the bill. These will be distributed in nineteen different buildings, four of which are to be neuropsychiatric hospitals for the care of the mentally ill.

The new hospitalization law specifically authorized \$400,000 for a general hospital at Salt Lake City, Utah; \$700,000 for a general hospital in West Virginia; \$450,000 for additional hospital facilities at Camp Custer, Mich.; \$1,050,000 for an addition to the hospital at Hot Springs, Ark., and \$1,850,000 for alterations and improvements on existing projects.

Under the Veterans' Bureau program, the following projects will be constructed under the authority of the

measure; a neuropsychiatric hospital, New Bedford, Mass., \$360,000; additional facilities at Northport, L. I., and a new hospital at Somerset Hills, N. J., \$1,900,000; a new hospital in New York City, \$1,000,000; a new neuropsychiatric hospital in western New York State, and additional facilities at Aspinwall, Pa., \$1,700,000; acute building at the Neuropsychiatric Hospital, Atlanta, \$300,000; Neuropsychiatric Hospital, Gulfport, Miss. (acute building), \$340,000; general hospital, Indiana, \$500,000; neuropsychiatric quarters, North Chicago, \$280,000; Knoxville, Iowa, building, \$270,000; General Hospital, Albuquerque, N. M., \$1,250,000; new hospital, San Francisco, \$1,000,000; additional beds at the Tuberculosis Hospital, Tucson, Ariz., \$280,000 and a new neuropsychiatric hospital, Texas, \$1,200,000.

### New York City to Increase Hospital Facilities

Construction of the first unit of the Municipal Hospital of Queens will be begun soon, according to an announcement made by Dr. William Schroeder, Jr., commissioner of sanitation, former commissioner of the department of hospitals.

In making this announcement, Doctor Schroeder outlined a building program, the most comprehensive ever undertaken by New York City, which within the next two years will add 12,000 beds to the present hospital facilities. The new Kings County Hospital, Brooklyn, will receive an additional 2,000 beds. Work will soon begin on the new psychiatric hospital for Bellevue Hospital, and plans have been drawn for a 1,000-bed tuberculosis sanatorium at Otisville.

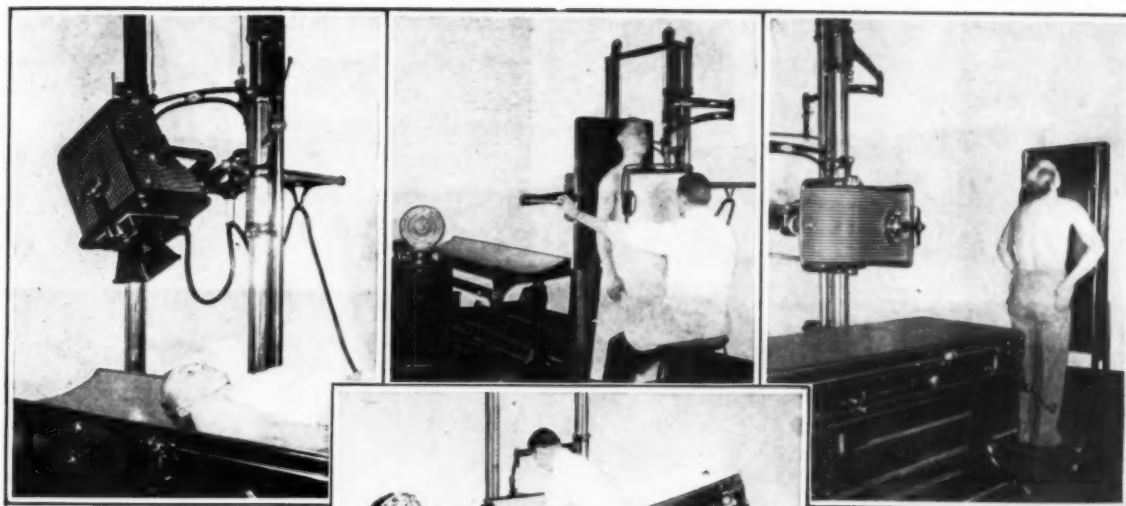
### Hospital for Middle Class Planned for New York

New York has instituted a campaign to raise \$6,000,000 for a 200-bed hospital for those who are not rich enough to pay the prevailing charges or poor enough to receive free care given by both doctors and hospitals to the indigent.

The new institution, to be known as Gotham Hospital, in addition to providing hospital care at moderate cost will serve as a demonstration center for new ideas in hospital management. Among its other innovations, according to the *Survey*, the hospital will give woman physicians an opportunity to serve on its staff on equality with men.

### Illinois State Hospitals to Be Enlarged

Contracts have been awarded for the construction of twenty-five ward units at the Elgin State Hospital, Elgin, the Chicago State Hospital, Dunning, and the Lincoln State Colony for the Feeble-minded, Lincoln, at an approximate cost of \$2,500,000.



(Upper Left) Radiography with the Potter-Bucky Diaphragm, curved type, which is an integral part of the table.

(Lower Center) Fluoroscopy, with the same tube head lowered and swung under the table. The change from one position of the tube head to another requires but a moment.

(Top Center) Vertical fluoroscopy, with the tube head moved down along floor rail into position, which automatically brings the fluoroscopic screen into working position.

(Upper Right) Vertical chest radiography is made possible by means of a cassette tunnel mounted on the back of the vertical fluoroscope.

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## NURSING AND THE HOSPITAL

Conducted by M. HELENA McMILLAN, R.N.,  
Director, School of Nursing, Presbyterian Hospital, Chicago

# The Central School of Nursing—Its Aims and Accomplishments

By ELEANOR E. HAMILTON, R.N.

Superintendent, Presbyterian Hospital, Newark, N. J.

THE organization of a central school of nursing requires considerable thought on the part of those who are interested in a central place for the teaching of probationer students and for the conducting of lectures for senior students.

Several types of central schools are now functioning successfully in the United States. The first one was built at the University of Minnesota. Dr. Richard Olding Beard, who has understood so clearly the problems of schools of nursing, together with Louise Powell, put into motion the machinery of the first university school of nursing. This school enabled the standardized schools in Minneapolis and St. Paul to enter students in the University of Minnesota. The nurse who was graduated from the dual course received her B.S. degree from the university and her diploma from the training school.

Soon after this, central schools, which were known as such, were organized in Kansas City, Mo., and in Grand Rapids, Mich. Both of these schools are backed by the boards of education of their respective cities.

### *A Unique School*

The Kansas City school is unique in that the school has become an active branch of the junior college of that city. The board of education provides the salaries of two nurse instructors. The course is well regulated. The policy of the junior college is to admit to the nursing course any student that any accredited hospital school wishes to send. A mental test is given to the students as they are admitted. On the basis of scores made, the group is divided into two or more sections. This division has proved successful, since it places the students in each group on an even educational basis. The groups are thus divided into the bright, the less bright and the slower students. Each student pays two and one-half dollars a term. This is paid by the hospitals that send the students and covers the cost of necessary equipment. Five hospitals in Kansas City are now using this course which has been functioning successfully for ten years.

Many other central schools have arisen since these three were started. Western Reserve University, Cleveland, George Washington University, Washington, D. C.,

and the University of Pennsylvania, Philadelphia, all have central schools of nursing.

In Cleveland, the school occupies its own buildings, and Western Reserve University directs the higher education of the student. Six schools in Washington, D. C., are affiliated with George Washington University. The same is true in Philadelphia where the University of Pennsylvania is the center for the group teaching of nurses. Several other universities have sponsored schools of nursing. Two that are outstanding are the University of Michigan and Yale University.

### *Are Nurses Being Overeducated?*

It is interesting to note, that, despite the running comment of a few years ago that nurses were being overeducated, these schools are going forward with new strides, new vision and new achievements, and they have brought about better training, more poise and greater dignity in the profession of nursing.

In a more concrete way, perhaps, the organization of a central school of nursing is more feasible when several schools are centered in one city where distances are not too great, when the basis of educational qualification for the student nurse herself is sound, when several schools agree as to an established standard of educational preparation and, finally, when boards of trustees of hospitals, physicians, superintendents and directors of schools of nursing agree on a centralized plan of education. This necessitates many adjustments, a small outlay of money per student and a central building. The first year is largely experimental. The various groups must be assimilated, the teachers adjusted and the students accustomed to broader territory than the confines of their own home schools.

On a closer analysis, it appears reasonable to establish a basis for preliminary education. This same established basis contributes to better end results and assures the success of the experiment.

Various groups will question the expediency of this method. They will cite expense, absence from the home hospital and the transportation of students to and from the central school. It may be emphasized, however, that

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no training of student nurses would be possible if young women did not desire to take such a course. With the desire is created the aim to receive training in some school where favorable conditions prevail and where the theoretical and practical training assures the best results.

Since it has been clearly proved in the last ten years that this type of school has been successful from the standpoint of the hospital, let us now look at the effect on the student.

### *Advantages of the Central School*

The first premise is that the graduate nurse shall be worthy of her profession. We expect her to have the following qualities: dignity, poise, assurance, tact, skill, knowledge and gentleness. We expect further that she shall take her place in the community either as a public health nurse, a school nurse, an industrial nurse, a visiting nurse, a Red Cross nurse, a mental hygiene nurse or a child welfare nurse. She may be a valuable asset to the community as a private duty nurse or to institutions as a superintendent, an assistant, a director of nursing, a supervisor, an instructor, an operating room supervisor, a clinic head, a social worker or a night supervisor. All of these are the ordinary and not unusual branches of work upon which nursing school graduates may enter.

The central school does one thing early in its career. It assimilates the groups, coordinates their various personalities, lends a wider vision to the horizon and levels all hospital schools practically to one status—the safe, sound and proficient care of the sick. Soon the students in the central school gain again another level, the basis of a common technique of performance. Taught by well prepared teachers, the students from six or eight schools begin to acquire a joint knowledge and procedure that are of lasting benefit.

The preliminary course may well be taught under such a plan. For the more advanced student the block system of training may be used. In this way her time for theory is blocked as is also her time for practice. As a result, the overturn on the wards and on the floors shortly resolves itself into order. The students on practice are not off for class. The patients receive uninterrupted care and the practical work for the student is planned according to her knowledge. Because her theory precedes her practice, she coordinates the two. While group No. 1 is off the wards two months for concentrated theory, group No. 2 is on the wards for practice.

Why should not this theory be taught in the central school, to which will come physicians who will lecture to one group instead of to several groups? The repetition of work for the teachers and lecturers is perhaps the only drawback. Many hospital groups for a long time have expressed the thought that the present status of the education of student nurses is on an unsound basis. Since the vast majority of schools have no endowment, of necessity they have become an integral part of hospitals. The financing of these schools comes through two sources: if the school is a part of a city institution, from taxation; if it is a part of a semiprivate, semigeneral or private hospital, from the private patient's purse. Along with other costs, this cost enters into the daily per capita cost.

Two avenues of organization might be suggested for a central school in a city where there are several hospitals. The first might be under the board of education. Since the board of education carries students through the high schools, a central school of nursing requiring a different type of knowledge would need to be of a special caliber. On the governing board of any organ-

ization that might operate such a school must appear persons with hospital contacts and nursing knowledge. The second avenue would be through taxation. Is it not reasonable to suppose that taxation offers a plausible plan for the support of a central school, together with such matriculation, course and laboratory fees as will guarantee the life of the project? The teaching staff of such a school would not be greater than the staffs that are now supported in several hospitals in a given city.

Nor should the training of nurse attendants be neglected. This could also be placed in one of the branch projects of the central school. At the present time, there are many places where practical nurses are unlicensed. We hear repeatedly of their command of the professional nurse's rate. The practical nurse has always been with us and will continue to be with us. She has a definite place in the community. She would, however, prove a greater asset if she had a certain amount of training. This could be accomplished in the central school. Like the graduate, the practical nurse should pass some state examination in order to qualify as a nurse attendant.

The central school to be a success must be established on well defined lines. Its lecturing staff of physicians and its teaching staff of nurses must be of a high order, its board of managers must be chosen with care and the project of the school must be kept always before the public.

## A Prevention Program Sponsored by State Hospitals

That the future of mental medicine lies in educational and clinical methods directed toward prevention is expressed by Dr. J. A. Jackson and Dr. H. V. Pike, Danville, Pa., in the *American Journal of Psychiatry*.

Every state hospital should assume a certain degree of responsibility in the development of a program of mental hygiene in its immediate district, they say. Such a program must be planned to include both educational and clinic extra-hospital activities. They stress the study of the preschool child with a view to correcting the forming of faulty habits in the early years of life. Many of these patients can be helped to make good social adjustments, by early observation and treatment.

The article suggests that neuropsychiatrists be employed by state departments of education to provide educational and clinical instruction for school physicians, teachers and school nurses.

## "Ward Administration" Is Welcomed as a Valuable Textbook

"Ward Administration," a textbook by Gladys Sellev, assistant to the dean of the children's unit, Cook County Hospital, Chicago, makes a valuable contribution to the development of efficient hospital service and should be read by all who are interested in the care of the sick and in the education of the nurse.

Persons interested in such problems as the proportion of nurses to patients, the distribution of nurses and their teaching and supervision, the education of the graduate staff and other details of hospital work should consult this book frequently. It is an excellent textbook.

"Ward Administration," published by W. B. Saunders Company, is limited to 290 pages, but Miss Sellev has managed to put into those pages the experience of her years of original study.





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## DIETETICS AND INSTITUTIONAL FOOD SERVICE

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# Two Problems of a Dietitian

By MARY W. NORTHROP

Dietitian, Montefiore Hospital, New York City

### PROBLEM I—"THEY EMPLOY ME FOR WHAT I KNOW."

A MAN who for many years had been engineer and building superintendent of a large hospital, resigned and accepted a position as engineer in an industrial plant. A few weeks later one of his former associates asked him how he was getting along. He replied that he was happy in his new work, and added, "They employ me for what I know, rather than for what I do."

His unspoken criticism pointed to one of the flagrant wastes in hospital administration. Few industries employ as large a variety of highly trained technical experts as does a hospital. No industry would expect such employees to work at their highest level of efficiency and productivity if they were forced to spend a large portion of their time in doing routine nontechnical tasks, nor would it be so uneconomical as to have high-salaried people doing work that could be done by others of lesser ability.

There is no better example of this than the work of the average dietitian. She is a highly trained, scientific and technical worker. Years of study have made up her preparation. She is expected to be a master of many trades. If she is the head of a large dietary department that controls the whole problem of purchase, preparation and service of food to all patients and employees of the hospital, many and varied are the problems that confront her.

#### *What the Dietitian Must Know*

She must be a skilled purchasing agent, able to compete in her knowledge of purchasing methods and markets with men whose whole business is food buying. She must be a good mechanic, able to direct the use and care and conservation of equipment in her department, and to discuss new equipment with the engineer and the representative of the manufacturer. She must act as the check on them, and must keep in touch with new developments in their field. She must know food preparation and kitchen management as does the chef, who has given his whole life to this one part of the business of food production. She must know enough of food cost

accounting to appreciate and understand the work the accounting department does for her or, if the accounting system of the hospital is underdeveloped, to explain to them what she wishes their records to show her. She has a housekeeping problem in her own department similar to that of the hospital housekeeper. She must be an expert in personnel management.

All this is of no avail, however, unless she knows how to plan a meal that is satisfying and nutritious at the lowest cost possible. She must be a good nutritionist and a good economist. She must have a feeling inborn and inbred for the highest possible standards in food and its preparation.

#### *Her Duties Cover a Wide Range*

To be an administrative dietitian, then, she must combine something of the skill of the purchasing agent, the engineer, the chef, the housekeeper, the accountant, the personnel manager and the nutritionist. Is that enough? Decidedly not. She is not allowed to specialize in administration without a knowledge of the other branches of her department—the therapeutic and educational divisions.

What of the so-called therapeutic dietitian? May she learn just her half of the field? Not at all. She has her kitchen to manage as well. She also is to some extent engineer, chef, personnel manager and economist. She must certainly be an expert producer of good food if she is to serve palatable diets in spite of the restrictions imposed by therapeutic work. Since the whole business of diet regulation has as its base normal nutritional requirements and as its superstructure the modification of the normal in meeting special diet requirements, she must be a good nutritionist and a good physiologist.

She must have an intimate knowledge of food chemistry and the effect of foods in the body. She must keep informed of the advances in her one branch of clinical medicine, diet therapy, in nutrition research and in the advances in knowledge about foods. She must know the psychology of the sick in order to secure the cooperation of her patients. In the average large hospital, besides keeping abreast of the times in the field of research, she is called upon to cooperate with the medical staff in its research problems, and to know, appreciate and carry

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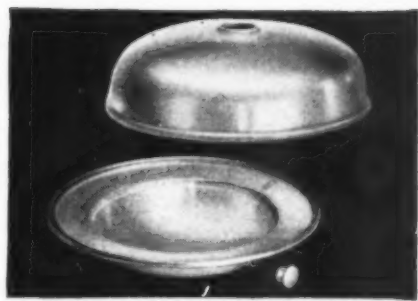
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out the minutely accurate technique of the research laboratory in the preparation of research diets.

And the teaching dietitian? Every dietitian is a teaching dietitian if she fulfills her obligations, but there are those among us who announce this as their specialty. Any teacher must know the subject matter she is to teach as well as the method of imparting it. The dietitian who teaches must, therefore, know food preparation, normal nutrition, diet therapy and pedagogy and, if her teaching is to be of practical value, she must have an appreciation of the principles of sociology and economics, of hospital organization and procedures.

Some of us, then, may specialize. The dietitian in the small hospital, however, and the head dietitian in a large one must retain a view of the whole field, keeping the sense of proportion, the appreciation of new developments and the flair for hospital organization as a whole which act as a balance wheel and keep the dietary department progressive.

This ideal is not impossible to a dietitian of clear vision, if the hospital is willing to employ her for what she knows rather than for what she does. She cannot do more than lay a foundation during her college training. Each year of her experience, however, should add richly to her knowledge. That it often does not do so, is an indictment both of the hospital and of the dietitian herself. The hospital should not expect, as it often does expect, that she will work understaffed, filling in the gaps herself by doing much routine nontechnical work. The dietitian herself should not fall into the habit of allowing a multiplicity of details to absorb all of her time.

The average day of an average dietitian in charge of a large special diet department will illustrate the point. She is on duty early. She checks her patients' breakfast trays before they leave the kitchen. She checks the supplies received from the storeroom, and writes orders for more supplies for the next day. She writes her menus. She keeps an eye on the kitchen to be sure that food preparation is proceeding properly. She calculates a few diets, copies slips and orders, makes a few trips to the storeroom or the offices of other departments. She answers two dozen telephone calls and does a little filing. At noon she checks trays again. And what of the afternoon? Part of her nurses have gone to class. Her assistant and some other students are off for the afternoon. She relieves them, writes more diets, checks her time book, records her diet census, takes an inventory of her dish supply preparatory to placing an order, answers more telephone calls, checks more trays and charts the day's diets. When these duties are finished, the day is gone.

### *Hospital Must Follow Industry's Example*

How many of the nine hours that she has been on duty have been spent in work that could have been done by a competent clerk? She has not seen her patients, unless she has made a hasty trip or two to the wards between times. She has not learned the wishes of the doctors with regard to those patients, except indirectly. She has been too busy all day to make certain that the student nurses working under her direction have really understood the reasons for what they were doing. An hour in conference with each one of them once a week would not be much, but she has no time for any conferences at all. The day has added nothing to her own knowledge that would make her more useful to the hospital in the future. She is too tired now to spend the evening in study.

To solve the problem, then, the hospital must follow in the steps of industry in conserving skill. It must stop using trained workers for routine work and must provide a sufficient staff to release its professional employees for professional work.

### PROBLEM II—EVERY COMMODITY HAS ITS MARKET VALUE.

The constant, low growl of the interns had grown to a resounding chorus of complaint which had reached the ears of the attending physician.

"What is the matter with hospital food, anyway?" the physician asked the dietitian. "I've been hearing this same story for twenty years, ever since I was an intern."

The dietitian took a breath. "Let us make a long story short," she said, "by discussing only one of the reasons we could give. We shall pass over the fact that the hospital system of making food a part of the wage breeds discontent, and we shall disregard the difficulty of cooking food in huge quantities and of serving it in perhaps five different dining rooms and fifteen wards, spread over an area of two city blocks. We shall start our discussion by asking a question. How much would it cost the intern to buy in a restaurant, food that, if it were served in a hospital, he would consider satisfactory?"

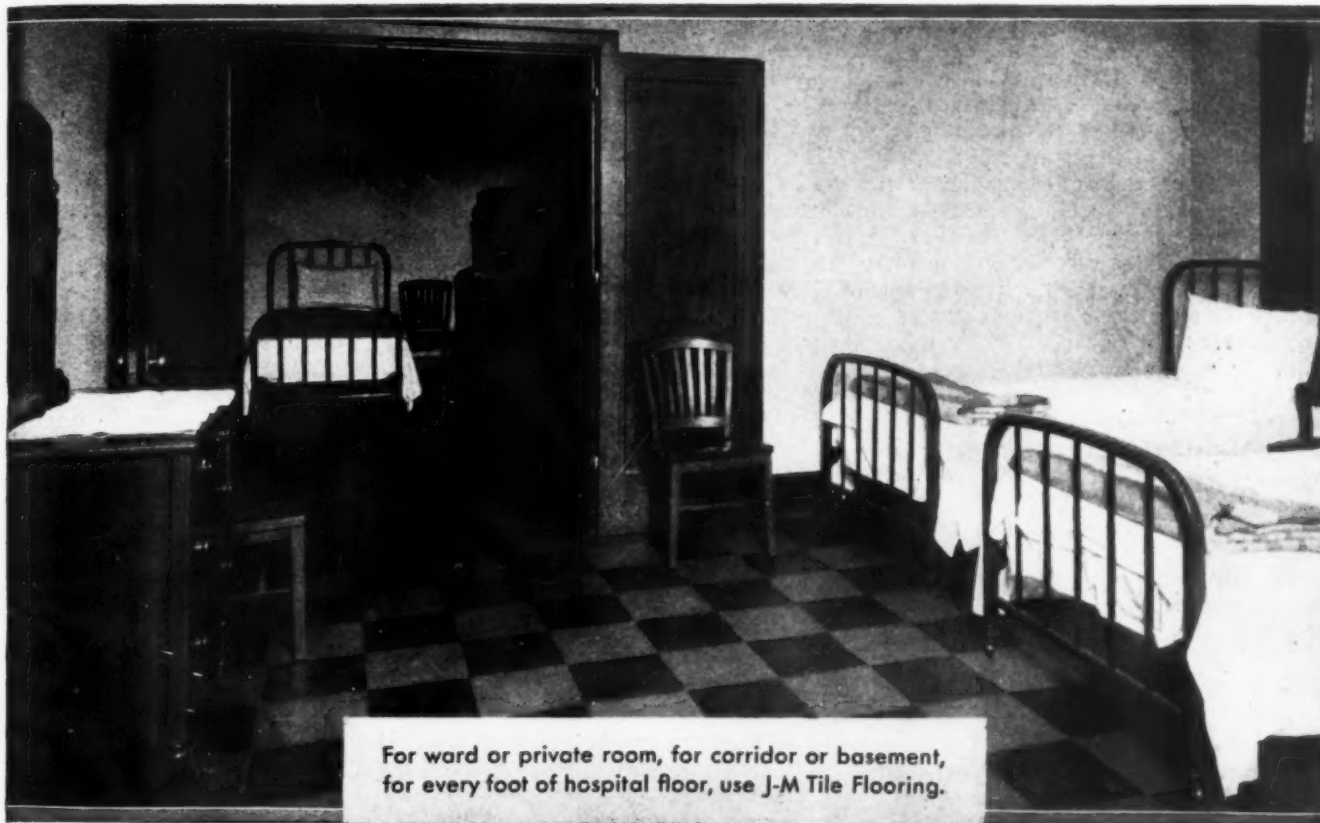
After some thought, the reply was, "Sixty cents for breakfast, eighty cents for lunch and a dollar for dinner. Two dollars and forty cents. That certainly would not be luxurious."

"No," said the dietitian, "and it would not include the sandwiches and coffee the hospital provides in the evening. May we add twenty-five cents for that? If the restaurant in which this \$2.65 was spent were operated as most restaurants are, the distribution of the money would be like this: 'for raw food, from 35 to 40 per cent; for labor, from 16 to 18 per cent; for overhead expense, from 25 to 35 per cent and for profit, from 10 to 15 per cent.'

"The hospital dietary department cannot easily compute its overhead expense and it makes no profit. Its food and labor costs, however, are comparable to those of the restaurant since the food and the labor are secured in the same market at the same price. When the hospital pays a lower price for raw food or pays to its employees a lower actual wage (not when only the apparent wage is lower, however, since to this is added the cost of maintenance), the difference is usually due to a difference in the quality of that food or that labor. Every commodity has its market value.

"Thirty-five per cent, then, of \$2.65, would be the cost of this satisfactory food to the restaurateur or to the dietitian. Thirty-five per cent of \$2.65 is ninety-three cents. Ninety-three cents is the market value of the raw food purchased to serve the intern for the day. About fifty-five cents is the daily per capita allowance for raw food in most hospitals. Of course we do not provide the varied menu supplied by the restaurant, which means that our percentage of loss is less. On the other hand, the element of choice that the varied menu of the restaurant gives is one of the chief factors that changes the discontented intern into a satisfied patron. I am willing to make allowance for this factor. Is 10 per cent sufficient allowance? That means that when we are given eighty-four cents per capita per day, an increase of about 50 per cent over our present allowance, we can be asked to compete with the restaurant in the quality and quantity of food served.

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"Then, as to labor: The restaurateur paid at least 16 per cent of \$2.65, or forty-two cents for labor. The patron added at least thirty cents to this in the form of tips. The total labor cost, then, was seventy-two cents for the day. Here the dietitian has little allowance to make, for her service problem is more difficult than that of any restaurant. Moreover, it is difficult for her to make any comparison because she seldom knows what her real cost for labor is. One dietitian, however, approximated her labor cost after this fashion: persons served per day, 980; persons served per month, 29,400; monthly pay roll of the dietary department, \$3,400; apparent cost per person served, 11.7 cents; estimated maintenance cost of sixty nonprofessional employees, \$3,300; estimated maintenance of ten dietitians and students, \$650; actual labor cost of dietary department, \$7,350; estimated value of time spent by graduate nurses, orderlies and attendants in food service, \$715; maintenance cost of such employees and student nurses (proportional to time spent in food service), \$1,015. The total monthly labor cost for food preparation and service was \$9,080 and the labor cost per person served per day was 30.8 cents.

"How do we account for the discrepancy between seventy-two cents, which includes tips or even the forty-two cents paid by the restaurateur himself, and the hospital total of thirty-one cents? Obviously, this must be done by employing less help or by paying lower wages, either of which must turn the odds against the dietitian in the production of good food.

"We dietitians are not complaining. We know that hospital budgets will not stretch indefinitely. We do feel, sometimes, that they stretch more easily for other departments than for ours. We do wish, however, that more of the world knew that the three factors, aside from efficient supervision, which operate in hospital food production are raw food, labor and equipment, and that the odds are against us in the first two, and not infrequently in the third. We wish you knew, in other words, that it is not always all our fault."

"My question has been answered," said the attending physician.

## How New York City Is Safeguarding the Health of Mothers and Babies

Every four minutes, day and night, a child is born in New York City—128,000 a year. Of this number, 7,200 die before they are a year old. More than half of these 7,200 babies die within the first month of their lives and about 40 per cent die within the first week. For every 200 children born, a mother dies at childbirth.

These are some of the facts brought out in a survey of New York City's maternity services made by the Welfare Council as part of its health inventory of the city.

To safeguard the life and health of these babies and their mothers, the public and private welfare agencies of the city provide an army of 204 doctors, 120 nurses, forty-two social workers and sixty-seven workers of other types, including nutrition workers, doctors and nurses in training, clerks and investigators. This force is exclusive of the much larger forces of doctors, nurses and midwives engaged in private practice.

There are ninety-one maternity clinics in the five boroughs of New York City, according to the inventory. Fourteen of these are maintained by the municipal department of health and seventy-seven are maintained by agencies

outside the department. Manhattan with 1,800,000 residents and 30,000 births a year has forty-six of the privately maintained maternity clinics; Brooklyn with a population of 2,274,000 and close to 52,000 births annually has twenty-one such clinics; the Bronx with a population of close to a million and more than 21,000 births annually has five maternity clinics; Queens with a population of nearly a million and 16,000 births annually has three maternity clinics; State Island has two.

### Prenatal Services Well Organized

New York City is credited with the first official recognition in this country of the responsibility of a city for the protection of infant life. This, according to the Welfare Council report, occurred in 1908 when the Division of Child Hygiene was established in the department of health. The development of prenatal services as a department of maternity work in New York City, the council points out, goes still farther back to 1907 when the Association for Improving the Condition of the Poor employed two nurses for this purpose. The first systematic effort, however, on the part of privately supported agencies to provide prenatal services came in 1915. Since then the work has grown so extensively that a recent appraisal revealed maternity hygiene as the only field of health services in New York City that scored 100 per cent according to the American Public Health Association's standard.

The Welfare Council's study of maternity services, the report says, raises a number of important questions. Chief among these are:

By what means can the recently enlarged maternity work of hospitals be standardized?

How far is it possible for the health department to control the standards of work of the hospitals and should responsibility for this be regarded as one of its functions?

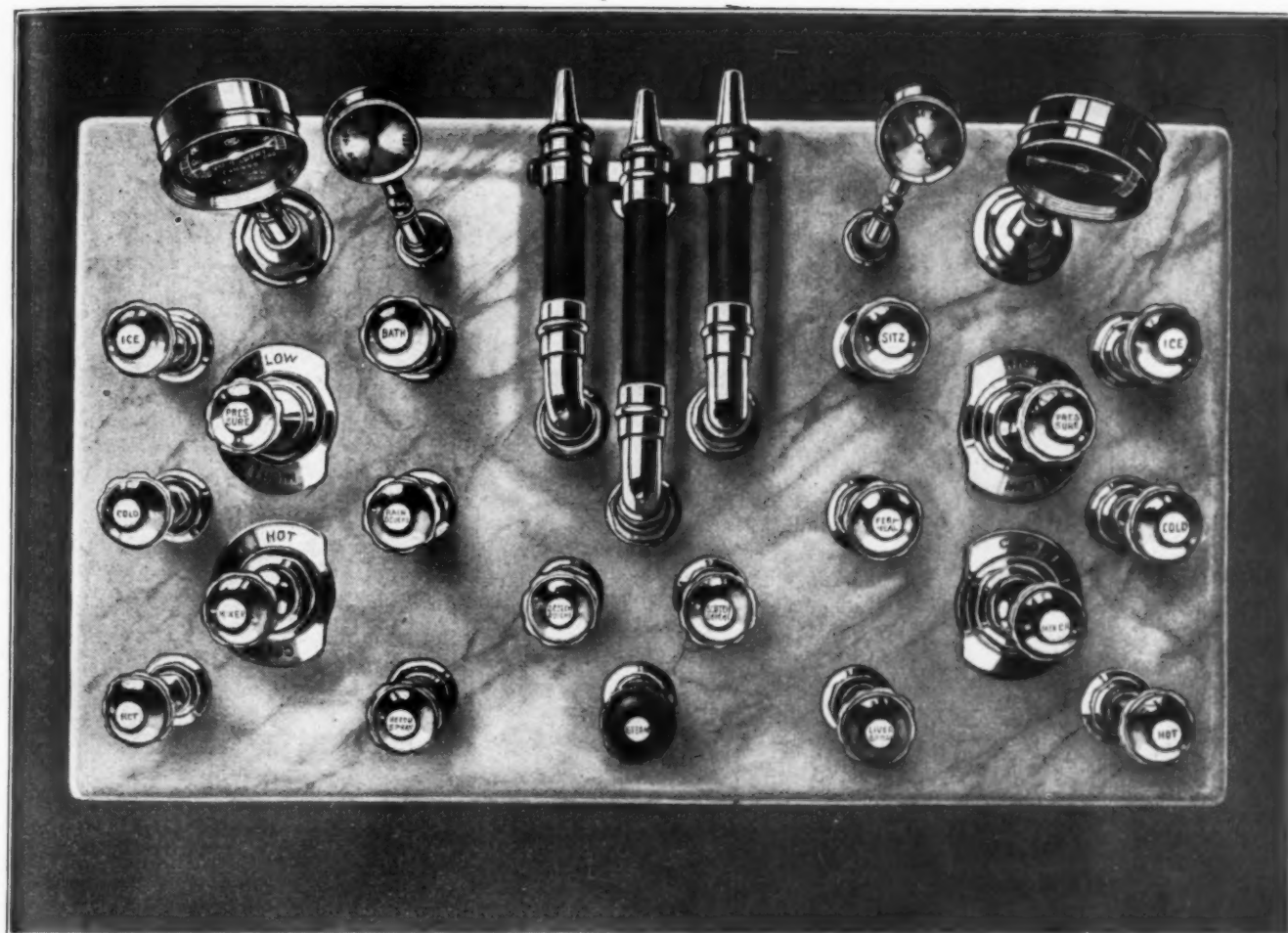
Should the voluntary or privately financed health and welfare agencies assume responsibility for developing maternity services in the boroughs outside of Manhattan in which it is markedly undeveloped?

"For certain parts of maternity service, particularly for nursing care, standards have been established and in general accepted," the inventory says. "There appears to be need for a formulation of combined medical and nursing standards with sufficient detail and with recognition of the medical, social and mental factors involved in maternity care, to serve not only as a minimum requirement but also as a standard toward which maternity clinics may develop.

"The fact that the outstanding voluntary agency in this field has limited itself to one borough and has recently concentrated its work along educational lines rather than along the lines of service and promotion, raises the question of the need for a voluntary promoting, coordinating and standardizing body working with the health department."

The study of maternity services, the most exhaustive inquiry of its kind ever made in this city, was conducted in consultation with executives of the following health and welfare agencies: Children's Welfare Federation; New York Nursery and Child's Hospital; Bureau of Child Hygiene, Department of Health; Maternity Center Association; Sloane Hospital for Women; New York Diet Kitchen Association; State Charities Aid Association; Bureau of Nursing, Department of Health; former commissioner of health, New York City; New York Tuberculosis and Health Association; New York Obstetrical Society; Maternity Center Association; New York Tuberculosis and Health Association; Long Island Medical College; Henry Street Visiting Nurse Service.

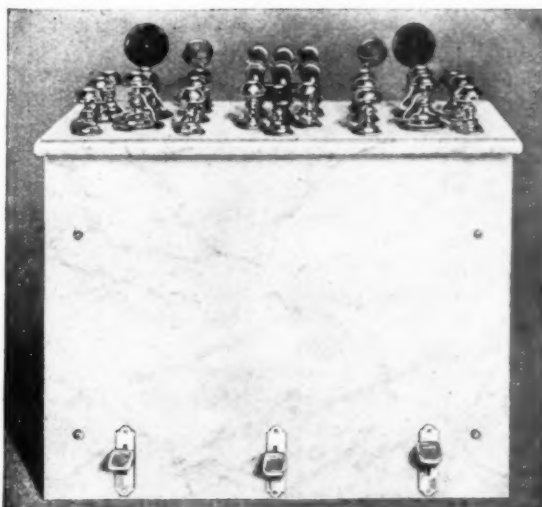




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Director for Medical Services, Julius Rosenwald Fund, Chicago

# Problems That Clinics Have Solved and Those They Still Face\*

THE appointment system of the Peter Bent Brigham Hospital, Boston, has improved conditions in the out-patient department by making possible a more uniform flow of patients together with more time to study them.

In the last few months, the time during which new patients are first seen by members of the resident staff has been increased to thirty minutes. New patients, seen first by clinical clerks (senior students), are allotted from one hour to one hour and a half for the primary history, physical examination, simple laboratory study and a check on these findings by a number of the visiting staff. All of the new patients can and usually do return on subsequent days for any needed special examinations, so that in the course of a short time all methods of examination carried out in the wards, with very few exceptions, are applied to ambulatory patients. The appointment system makes possible the return of the patients at a time convenient for these special examinations and for as long a time as is needed at each visit, the range for return visits being from five to twenty minutes.

The intelligent use of these possibilities should provide enough time to study each patient satisfactorily. Obviously, however, the more time given to each patient, the fewer the patients who can be handled daily or yearly. Still, it is more important to do good work than to treat many patients. Actually with the present system, many patients may be treated, and each patient have devoted to him such time as is necessary.

### *Record Keeping Offers a Problem*

Keeping the records of patients in the out-patient department presents a difficult problem. Records of individual patients are being improved gradually. Just how complete they should be is open to discussion. All essential positive findings and all important negative findings should be recorded. Social service records, the important data at least, should be combined in some way with the medical and surgical out-patient department cards. Better utilization of house records in connection with return visits to the out-patient department of patients formerly in the house could and should be facilitated by an efficient messenger service.

A good reason for keeping separate house and out-patient department records is the fact that many of the out-patient department patients have minor illnesses, requiring no elaborate record. These would be a heavy incubus on any plan of clinical history begun in the out-patient department and continued in the house. After all, relatively few out-patient department patients need to enter the house, and many of the house patients returning to the out-patient department are discharged for follow-up in the special clinics in which are used special forms of recording suited to the different needs of the particular disease of the patient. For these and other reasons, the utility of attempting to keep for out-patients the same complete, typewritten history record used for house patients is doubtful.

### *The Advantages of a Single Record*

A single history record for any given patient covering all admissions to any part of the hospital would have many advantages and it would also save much duplication. No plan, so far suggested, however, has seemed practical enough in the details of its working to justify its adoption. Doing away with separate services would be a step in the direction of the single history system. It is difficult however, to fuse out-patient department and house records into a system that will make possible for each patient a single continuous clinical record. The readmission of patients after long intervals of time is another difficult feature of record keeping, since it necessitates the perpetual handling of each history as a unit in some form that is inexpensive, strongly bound and so planned that new pages may be inserted easily. As this plan is carried out elsewhere, the records are either poorly protected from damage while they are in use, or their cost is prohibitive because the expenditure involved is entirely out of proportion to any actual benefit to the patient and to the hospital staff. Little by little, out-patient department records will continue to be improved and an ideal system eventually will be evolved.

Another unsolved problem in the out-patient department is how to get to the referring physician an adequate report of findings and suggestions as to treatment. With a separate diagnostic clinic, it could be accomplished easily if a stenographer were available at the end of the clinic hours. With patients coming at any hour through-

\*Condensed from the report of the physician-in-chief of Peter Bent Brigham Hospital, Boston, 1928.

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out the day, and with the staff needing to confer promptly with the next patient on the appointment list, it is doubtful if the one who can give the best report, namely, the man who has just seen the patient, can get in touch with the stenographer by any system of reasonable cost. A brief report is sent to the referring physician, although in its present form it is little more than a gesture of willingness to cooperate. However, some way to improve this should be found. After all, the great difficulty with all ambulatory clinics is that they are too large. How to keep them from increasing in size is the real problem.

It is the plan for a senior member of the staff in rotation to be in charge of the medical out-patient department. During this period he makes it his major interest. As the staff members study the problems of the out-patient department, better ways of handling ambulatory patients will result. As work is improved, the patient, who can accurately be called ambulatory, will be managed entirely in the out-patient department and sent to the wards only for special treatments, including surgery, which cannot be carried out in the patient's home. This will free beds in the hospital for such special treatments and for the care of acutely ill patients. To enhance further the efficiency of a service, there should be more beds available for convalescent patients and for those with chronic diseases.

### Dental Service—What It Means to Hospital and Clinic Patients\*

Progress in medicine, as in most things, takes an undulatory course. This force and that force swings the pendulum beyond the point of stable equilibrium, first in one direction and then in the other. In time, the pendulum regains its equilibrium, rests a while and again is set swinging by another force. Because theories in medicine act like these forces on a pendulum, medical ideas swing back and forth all of the time. A few years ago the theory of focal infection was advanced in explanation of many of the subacute and chronic ills of the body. Many cases were reported that indicated a direct casual relation to foci of infection, the eradication of which resulted in cure. That such relations do exist none will deny, but that they are of such extreme frequency seems improbable.

The theory once advanced, like the pendulum, seems to have swung too far in one direction. Of all possible foci of infection, teeth, perhaps, most often have been incriminated as causes of disease. This has resulted in more careful examination of the teeth and better dental hygiene, both of which are desirable. On the other hand thousands of sound teeth have been extracted in the belief that they were serving as foci of infection. Medical authorities have tended to lose sight of the importance of well kept teeth as organs of mastication, necessary to normal digestion. Because proper dental hygiene not alone improves the masticatory function of the teeth but decreases the frequency of infection about the teeth, it helps to keep the teeth from becoming foci of infection.

Hospital records and examination of patients at Peter Bent Brigham Hospital show that good teeth are the exception. Pyorrhea, dental caries and missing teeth are almost the rule in these patients, and an x-ray examination frequently reveals infection at the roots of the teeth. Foul smelling mouths naturally accompany bad

teeth. Normal appetite and good digestion are impossible under such circumstances. Missing teeth result in unopposed grinding surfaces, in poor mastication and in taking into the stomach food parts too coarse for prompt digestion. These dental defects contribute more frequently to ill health than do teeth in the rôle of focal infections. Yet teeth as possible sources of infection receive much consideration, while teeth as defective masticatory organs are getting scant attention in the hospital. The reason perhaps is that treatment for the former condition is relatively simple and can be quickly and inexpensively carried out—a suspicion, an x-ray, an extraction. On the other hand, treatment for the latter condition is time consuming and consequently expensive.

Dental work in the hospital will never be effective unless some of the work can be done in the hospital, and unless provision is made for the dental inspection of the mouths of all patients and for some regular arrangement by which these patients may be sent to a dental clinic where their diagnosed dental deficiencies will be corrected.

Since the opening of the Peter Bent Brigham Hospital there has been an unpaid consulting dental surgeon, but this arrangement has never been satisfactory. The men who have served in this capacity have given of their knowledge freely, but they cannot be expected and should not be asked to devote enough of their time to care for all of the work required even by ward patients. There is nothing of training and little of interest to justify asking the dentist to spend much of his time in hospital service, although actually many hours of his time are needed if his work is to be done with approximate thoroughness.

A salaried part-time dental surgeon for supervision and full-time paid workers to take care of patients' mouths are needed. Dental chairs and dental instruments and a place for them are essential. To install these facilities would greatly improve the care of patients. It would cost a moderate sum. There would be needed an annual expenditure for salaries. Such expenditure would add a far more than proportional improvement in the care of patients. By such a plan some of the most necessary work could be done for ambulatory patients coming to the out-patient department in addition to the work done for ward patients. For out-patients, however, the volume of work would be too great for such a modest outlay as is proposed here and they should be cared for by some large dental clinic willing to cooperate with the hospital.

### This Dental Clinic Is a Vital Part of a Successful Health Program

In a recent article in "The American City"<sup>1</sup> Dr. John J. Sippy of the San Joaquin Social Health District of California reports a useful piece of public health work. The San Joaquin Local Health District, he says, has evolved a special division of work, coordinated, of course, with the school health and development program. The duties of this division are: to cooperate with the local dental association in oral hygiene education, to conduct demonstration work in schools and to care for indigents unable to employ dentists.

All work is carried on by and with the advice and endorsement of the local dental association. Demonstration work in schools is limited to children under twelve years of age, or until the appearance of the permanent teeth. Service is given free to all applicants, since it is

\*Condensed from the 1928 report of Peter Bent Brigham Hospital, Boston.

<sup>1</sup> Demonstrating Dentistry in the Schools as Part of a Public Health Program, John J. Sippy, M.D., District Health Officer, American City, December, 1929, p. 106.

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regarded as an educational and not a charitable enterprise.

On account of limited time and personnel, treatments are necessarily restricted to such as may be performed at one sitting, but include cleanings, extractions, fillings and temporary cavity or pulp treatments. Children requiring continued treatments are referred to private dentists or, if indigent, they are cared for at the district's dental clinic at Stockton.

This dental clinic is conducted in the Henry Hewlett Hough Memorial Clinic at the Emergency Hospital from 1 to 5 p.m. each day, and is open to applicants from any part of the district, all of whom, however, must obtain entrance permits from the social welfare worker or investigator.

Work in rural schools is conducted in a dentist's office fully equipped for emergency work, mounted on a truck chassis. A second dentist, who operates in Stockton city schools for half of each school day, carries a portable outfit, the larger city schools having a rest room or other space apart from classrooms in which the set-up may be made. The other half of this dentist's day and his Saturday mornings are given to the Henry Hewlett Hough Memorial Clinic for indigents.

Both dentists devote full time on salary and are not permitted to do private practice. Women dentists are preferably employed for several reasons, among which are their tactful approach to children, their preference for work with children as a specialty and their disposition to remain permanently.

The dentist's salary at beginning of employment is \$150 a month. If the work is satisfactory after ninety days' probation, this is increased to \$175. Thereafter an additional \$25 a month is given for each year of employment until a maximum of \$3,000 a year is reached. A truck driver is employed at from \$100 to \$110 per month, usually only for the ten months of the school year.

A typical annual expenditure is as follows:

Salaries .....	\$5,265.73
Equipment .....	97.35
Transportation	
(a) auto maintenance .....	\$486.99
(b) other travel expense .....	215.85
Printing .....	171.50
General supplies .....	204.92
Special dental supplies .....	763.99

In accordance with this schedule, the cost of operation of the division has been as follows for the fiscal year ending June 30 of each year:

1925 .....	\$7,125.97
1926 .....	7,206.33
1927 .....	9,099.98
1928 .....	8,023.05
1929 .....	7,779.48

The increased cost for the year 1927 resulted from the purchase of a new truck chassis as a replacement.

The experience of the local health district in this work has been: 66 per cent of parents of school children from six to twelve years of age request examinations or treatments, many families, of course, preferring to employ private dentists; 23½ per cent of those examined had no new cavities or were immune to caries; 76½ per cent had cavities and received attention. Of these 39.8 per cent were immediately corrected; 22 per cent were referred to the free clinic and 38.2 per cent were referred to private dentists.

In the five-year period ending June 30, 1929, 72,850 treatments were given, consisting of: cleanings, 39 per cent; extractions, 17½ per cent; fillings, 36½ per cent; other treatments, 7 per cent.

During this period the district served 35,196 children at a total cost of \$39,234.81. The value of the service estimated on a minimum fee schedule was \$90,696, an average of \$2.58 to each child. The cost averaged \$1.15 a child and 54 cents an operation.

## Providing Clinic Care for Chinese Mill Workers

Less than ten years ago Hongkew, on the outskirts of Shanghai, China, was a region of farms and cultivated fields, according to the 1929 annual report of the Hongkew General Dispensary, Shanghai, China. To-day huts of mud and straw closely crowd the old farm dwellings. These house the many families from the country who, attracted by the establishment of silk mills and factories, have thronged into the vicinity and set up their homes in congested quarters completely lacking in sanitation. As a result, epidemics of disease and widespread ill health have become prevalent among these formerly healthy people.

To combat this situation the Hongkew General Dispensary was started in 1925 in a small Chinese house on Tien Teh Road. In 1928 it moved to a large three-story building on the Ling Ping Road, its present quarters. The first floor houses the clinic; the members of the staff occupy the second floor; on the third is a large sunny ward for the care of sick children.

Clinic hours are from 12:30 to 4 o'clock every afternoon. A third of the patients are children. Many of them suffer from the diseases of malnutrition, such as marasmus, rickets, scurvy, beriberi and pellagra; others are anemic, poorly nourished by improper food and likely to become tuberculous. The following clinics were held during the six months ending September 1, 1929:

Name of Clinic	No. of Visits
Minor surgical .....	1,463
Accidents .....	398
Medical .....	1,553
Skin .....	307
Tuberculosis .....	81
Eye and ear .....	353
Dental .....	29
Lepers .....	200
Miscellaneous .....	108

Total treatments .....

The clinic for lepers was started in January, 1929. Two hundred visits were made to it in the first eight and a half months and 258 treatments were given. Results have been satisfactory for all who returned regularly.

Silk mill workers, coolies employed on wharfs, in stores and in laundries, and farmers constitute the majority of the clientele. These people are too ignorant to understand and carry out directions or to know what results can be expected from the treatment they receive. Thus the workers at the clinic must fight not only disease, dirt and infection but also lack of comprehension and dark superstition as well. Trained social workers are badly needed but the limited funds at the disposal of the dispensary—only \$3,585 in the last year—prevent their employment as well as the carrying on of much other necessary work.



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## HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by C. W. MUNGER, M.D., Director,  
Grasslands Hospital, Valhalla, N. Y.

# Devices That Simplify the Care of Walls and Floors

CARE of walls and floors is one of the most important aspects of hospital maintenance. The variety of materials used for flooring and the differences in finishes applied to walls, combined with the necessity for aseptic cleanliness in most parts of the building, complicate the problem considerably.

Of first importance in the care of the walls and floors of a hospital is a realization of the general principle that there is no one best cleaner and no single method that will work in all institutions regardless of size or type of surface. As with every other problem, the problem of the maintenance of walls and flooring will never be solved by a panacea or a cure-all.

In this article it will be possible only to "hit the high spots" in the care of walls and floors. Generally speaking, it may be said that mechanical equipment is available which will considerably reduce the labor costs of painting at least, and also of cleaning floors. Most of the devices for cutting costs here named will be familiar to experienced hospital executives, but they are recounted for the benefit of those who are entering the field or who are charged with the erection of new buildings.

Considerable variance exists among those who recommend types of cleaners based on their own individual experience. After all, even the devices here named should be tested for adoption in any particular institution. Before the care of specific types of surfaces is discussed, some of the general problems will be considered.

### *Paint Spray Gun Has Advantages*

Painting with spray guns is now an accepted practice in industry, and there seems to be no valid reason why the hospital field should lag behind industry in this important economy. The usual portable outfit consists of a truck on which are mounted an electric motor, an air compressor and an air tank. Institutions that already have compressed air can dispense with the air compressor at a considerable saving in first cost of the sprayer. One man and a compressed air apparatus, functioning properly, can do the work of from three to five painters using a brush. This machine will cover from 500 to 1,000 square feet per hour and will distribute the paint more evenly than it can ever be distributed by hand brush.

Another advantage is that it will paint pipes and exposed electrical conduits, and also paint above such piping when it is placed under the ceiling or behind it when it is placed

along the wall. If the user wears a suitable respirator, there is no danger of lead poisoning. The sprayer will plug into any electric outlet and may be used in almost any place. There need be no fear that the machinery will completely eliminate the jobs of painters, because window and door casings and other detail work will have to be done by hand.

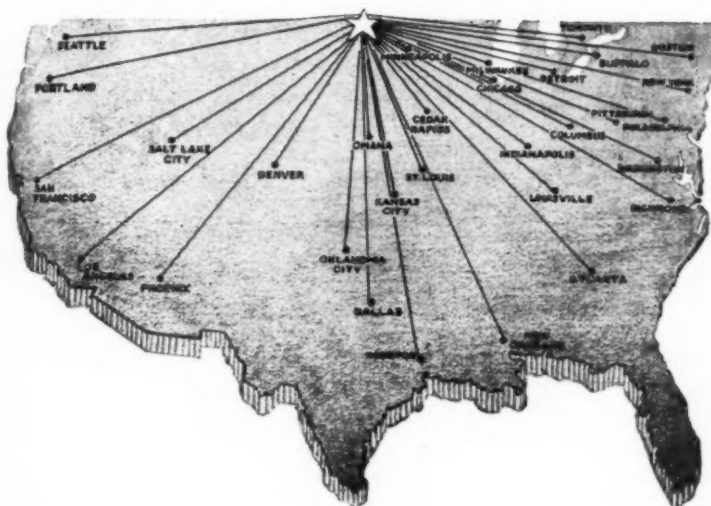
### *Electric Machine Used for Floors*

Of equal importance is the device now used in most large institutions, an electric machine that serves as a combination floor scrubber, waxer and polisher. With this machine one man can wax and polish more than 16,000 square feet of flooring in one day. It can go under objects as low as six inches from the floor and will distribute wax much more evenly than it can be distributed by hand. There are several different makes. In case dry wax is used, the machine revolving at high speed melts the wax, forces it into the holes of the linoleum and leaves the surface so hard that it cannot be marked by the heel. Some of these machines are made with tank attachments to hold liquid wax and distribute it direct to the brush. This dispenses with one operation—the spreading of wax by mop prior to polishing. It is claimed that most of the machines have these advantages at least: three to eight times as much brush surface as a single brush; twenty to thirty times as much force as a single brush; the ability to cover ten to twenty times as much floor area. The cost is not excessive, and there can be no doubt these machines pay for themselves in short order.

Vacuum cleaning is unanimously accepted as the best method of cleaning rugs and similar floor surfaces. It is generally believed that portable vacuum cleaners in the necessary quantities are superior to a single centralized vacuum cleaning system. Portable vacuum cleaners are made with dust blowers attached which can remove the dust from telephone switchboards, pianos and other places difficult of access. The bag type is light, easy to handle and can be started and stopped where the work is to be performed due to the fact that its power comes from an ordinary light outlet. A vacuum cleaner should always have all dust removed from its bag before being put away.

A practice which considerably reduces costs of repainting rooms and walls and yet which can be hardly called mechanical equipment is the application of a starch

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glaze to walls as soon as they are painted. A mixture of starch and water is put on the walls in a thin coating. When the walls are soiled, the dust and dirt may be washed away with the starch. For the new season, another covering of starch may be applied to the walls with a flat wall or calcimine brush. The glaze is made by solution of ordinary laundry starch in warm water and is inexpensive, especially in comparison with new paint. The walls may be washed every two or three months, or whenever necessary, and the frequency of repainting may be considerably reduced.

Purchase of cleaners for floors cannot be satisfactory if a single cleaner that will suffice for several different kinds of flooring is sought. Some cleaners, such as trisodium phosphate, are said to be suitable for all purposes, but authorities agree that they are not since they are bad for tile, linoleum, rubber and paint work. Purchase price alone is a dangerous guide as is also the claim that a particular cleaner "goes further." The superintendent must study the quantity needed for his purposes, the labor effort and the appearance of the finished floor, and base his decision whenever possible on actual tests.

### Chemical Versus Mechanical Cleaner

Considerable difference of opinion exists as to whether the cleaner should act mechanically or chemically upon the surface to be cleaned. The consensus of opinion seems to be that the friction cleaners are more satisfactory than chemical cleaners especially for tile and colored tiles. The objection to the chemical cleaners rests chiefly in the fact that they contain an excess of alkali which causes colors to fade and run. This is especially important in these days of the increasing use of color in hospitals. It is also claimed that the chemical cleaners attack rubber, tile, composition and other surfaces, softening them and shortening the life of the floor materially. Some of the mechanical cleaners are also objectionable, but there are available abrasive cleaners made of volcanic ash, flaky in form, which break down under pressure and which do not scratch or dull even the most highly polished surface.

Polished marble is one of the most satisfactory materials from the standpoint of cleaning compounds for it requires only clean water and rags. Soap, soap powder, soft soaps, lye, caustic cleaners, acid, oily sweeping compounds or harsh abrasives should not be used on marble. Sand-finished or honed interior marble, which is extensively used for floors, stair treads and the like, should be mopped or scrubbed regularly. If marble walls and trim become soiled and discolored, the cost of restoration is not great. However, careful attention to regular washing and strict adherence to the prohibition against the use of soaps which ultimately cause a disagreeable yellowish appearance will ensure against the necessity of restoration.

Tile should be cleaned daily with warm water, soap and a mild detergent. Strong solutions of lye or soda should be avoided because they eventually turn tile yellow. Harsh abrasives should also be avoided because they roughen the surface so that foreign matter clings easily to it. Scrubbing with a brush is not needed; mopping is sufficient. Rust spots around radiators and other equipment should be removed with hydrochloric acid followed by generous flushing with clear cold water.

Composition floors may be cleaned in the same way as tile.

Rubber floorings and rubberized materials have the lowest maintenance costs of any type, since neutral soap and warm water keep them in good condition. Use of a brush should not be necessary, but a brush will not harm them. The trend toward color in the floors of hospitals can be followed to any desired extent with these materials.



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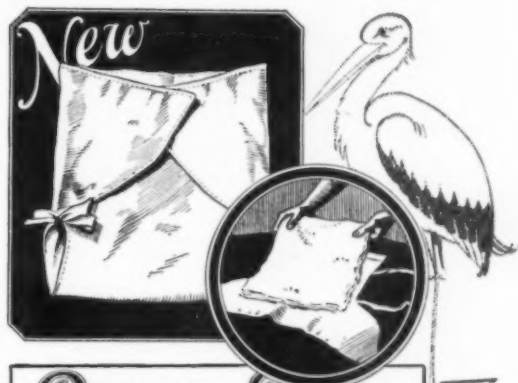
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Each Downee-Didee used saved 2½ pieces of laundry, or from 35 to 38 pieces a day for each baby.

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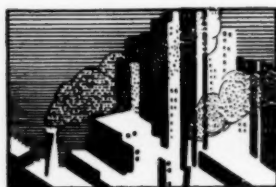
Downee-Didees are easier and quicker for nurses to handle than ordinary diapers. When soiled or wet, the Dee-Dee Pad is quickly removed and easily disposed of as ordinary tissue.

Because there are no soiled diapers to handle, and because they save the handling of many other pieces of laundry by preventing pinning blankets and bed linen from becoming soiled, they also save time and labor of other employees.

*\*Name of hospital and details of tests will be sent upon request. Write for complete information.*

Downee-Didees are also made in adult sizes for persons who are incontinent. Information upon request.

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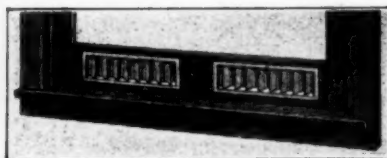


*"Hospitals are usually in populous areas, where smoke, dirt and traffic gases have a definite effect upon the sick."*

—From Hospitals of Today

True; unless a ventilation system is provided to eliminate these unhealthy effects. Since the sick must have fresh air to get well, it is important that the best possible ventilators be used.

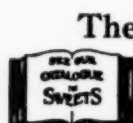
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Concrete and cement should be scrubbed or mopped with lye and should then be wiped with a mop and clear water. If they are not rinsed with this second mopping, the first mopping is apt to streak the floor.

Terrazzo should be mopped with a solution of green soap and water. In private rooms, it should be scrubbed with brushes, then with cleansing powder, and thoroughly rinsed. Corridors should be cleaned twice a day and private rooms once daily.

Linoleum floors, whether of the battleship, inlaid or cork carpet type, should be waxed and polished. If dirty they should be cleaned with warm soap suds before they are waxed. Soap and soap powders containing alkali are not used on linoleums because they eat into the oxidized linseed oil and decrease the length of life considerably.

Some there are who object to wax on linoleum floors because it makes them slippery. Recently a substitute for wax has been developed in the form of a shellac similar to that used on automobile bodies. This does not need scrubbing or polishing. It should be rubbed daily with a dry mop to take up the dust. This treatment improves the finish. The coat of shellac may be renewed every six months.

Wood floors, both hard and soft, will last longer if they are waxed. Sections that bear the burden of heavy traffic may need frequent attention between the regular polishing times even though the wood is shellacked and varnished.

### How Windows Should Be Washed

Window washing is one of the most troublesome of maintenance jobs. Because ease of maintenance is dependent partly upon construction, those in charge of new buildings should consider the labor costs of cleaning windows when they are deciding upon the type of frames and sashes. Small panes separated by wooden partitions should be avoided. Steel frames are now available with a reversible feature that permits the outside of the window to be washed from the inside of the house. This effects a considerable saving of time and money spent for labor. Screens should be hinged or so designed that they can be removed from the inside.

Soap should not be used on windows. A tablespoonful of ammonia to every half bucket of water used will clean the windows in excellent fashion. Apply this solution with a cloth, wipe the window with a chamois, and polish with a clean, dry cloth. On tall windows, the washer may want to use a long window brush, follow it with a squeegee and place a chamois over the rubber to finish.

There should be a definite and well understood allocation of all cleaning duties to individual workers. The frequency of cleaning and painting will vary with local conditions, but for walls quarterly cleanings and biennial paintings are a reasonable maximum. Administrative offices and public rooms may be cleaned at night, including the entrances to the hospital, lobby and the reception room. In large institutions it will doubtless be good organization to keep a crew of men busy with the rewaxing of linoleum and other soft floors. In all cases, every square foot of floor, wall and window space must be definitely assigned to one individual who can be held responsible for the cleanliness of the space. Whether the cleaners report to the housekeeper or to the nurse supervisor or to the chief engineer is not so important as the definite division of duties among the individual cleaners so that there can be no "passing of the buck" among them.

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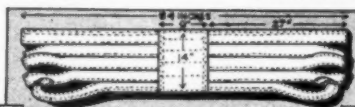
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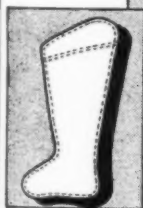
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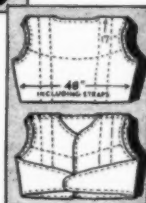


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brushes should be used first in the private rooms, then in corridors and stairways, then in the basement and boiler room and finally on the sidewalk. In this way maximum use will be made of them. Brushes should always be hung up by the handle with the bristles away from the wall. Length of handles should be adjusted to suit the individual user since there is a distinct relation between the length of the brush handle and the ease and rapidity with which the brushing is done.

### Caring for Scrubbing Brushes

After each use of a brush all lint and other dirt should be removed by thorough combing with a nail brush. The nail brush is made of sixpenny finishing nails driven through a wooden handle. The ends of the nails are rounded by being dipped in solder so they will not tear the bristles. If the dirt is not removed regularly it soon forms a thick mat and destroys the efficiency of the brush. Brushes used for sanitary closets should have short handles and after use should be thoroughly washed in cold water. To clean between radiator coils, a brush with stiff bristles and with a twisted wire handle about three feet long should be used. This brush should be kept dry and should also be combed out frequently with the nail brush.

The life of brooms may be prolonged by covering the straws with an old woolen sock, the foot of which has been removed. Scrub mops should be removed from their holders after use, washed in a solution of one pint of cleaning compound to nine quarts of water and hung up to dry. Sweeping mops should be rinsed in warm water until clean and then hung up to dry.

With the growing use of acoustical materials in hospitals, the painting and cleaning of these preparations present a new problem to hospital administrators. If the paint closes the pores of these materials, their absorbing efficiency is reduced. However, most acoustical plasters may be sprayed with paint without serious effect. If the painting is done by hand, great care should be exercised by the painter when covering these surfaces. It should be remembered that acoustical materials which have been stained cannot be washed without removal of the stain.

There are many small details to watch in cleaning walls and floors. In washing walls, particularly those that have not been treated with a starch glaze, the washers should begin at the bottom and work up. If they start at the top, the wall will be streaked with dirty water. It is easy to wipe water off clean paint, but when the water runs into the grease and dirt that form the film over unwashed walls it leaves a mark that cannot be removed.

### Cleaning the Ceilings

Importance of the ceilings especially in private rooms cannot be overemphasized because the patients gaze at them much of their time. Ceilings should be brushed down at least once a week. This treatment eliminates the possibility of an accumulation of dust and webs and helps to ward off discoloration.

Walls and floors must be protected from contact with furniture and equipment. A wide strip of molding around the baseboard of corridors and rooms will stop the progress of wheeled vehicles in time to prevent their contact with the paintwork and plaster. Wheeled equipment may also be provided with bumpers of rubber, rubber tubing or heavy water hose where needed. This costs little and does not detract from the beauty of the building or the usefulness of the wheeled equipment. Baseboards six or eight inches high will prevent the soiling of walls when mopping by hand is necessary.

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Hospitals that have used hard floors such as tile and cement in their ward rooms often receive complaints concerning the coldness of the floors. Cold floors may impede the recovery of convalescent patients and may also cause ambulant patients or those who are using crutches to slip. Some institutions set blocks of linoleum about six feet by ten feet where each bed is to stand, the surface being flush with the hard floor. But this is not much warmer, and a much superior device is to place bedside rugs about three feet by six feet near the beds. These are easily cleaned and permit the removal of the rugs and any desired change of position of the beds if the layout of the ward is changed. If the ward is long, a linoleum runner down the middle aisle between the rows of beds will minimize the injury to nurses' feet from hard floors.

It has not been possible within the limits of this article to touch all the details of the problem of caring for walls and floors. Attention has been centered upon some of the newer equipment and upon some of the most common devices to secure economy, which will be applicable to most institutions.

## A Couch That Promises Repose for Physical Therapy Patients

By WILLIAM BIERMAN, M.D.

Director, Department of Physical Therapy, Sydenham Hospital, New York City

Although it has been customary to use wooden tables or plinths in the administration of physical therapy treatments, another type of device that during the past few years has been found to be more convenient for the repose of patients during treatment may be aptly termed a physical therapy treatment couch.

The couch is made up essentially of a metal frame, placed on legs made of tubular steel, on top of which there is a coil spring. Into the bottom of the legs are inserted wooden gliders. The spring is so made that its head may be readily elevated. On top of the spring is placed a



*A thick felt mattress covered with imitation leather aids in making this couch comfortable for the patient.*

thick felt mattress, covered with imitation leather. Extending down from the mattress is a valance of material similar to the mattress cover. This valance completely encircles the entire couch and extends to the floor. The couch is twenty-six inches high, thirty inches wide and six and a half feet long.

Patients appear to prefer being placed on these couches while they are undergoing physical therapy treatments, rather than on the usual hard wooden plinths. All the usual types of electrotherapeutic procedures can be satisfactorily administered to the patient on this couch. Obviously it is not suitable for the application of static

## For the meatless diet— a dish to tempt and cheer

### Cream of Wheat Salmon Loaf

1 cup cooked Cream of Wheat  
1 can salmon 2 eggs Salt and pepper

Mix Cream of Wheat with salmon and beaten eggs. Season with salt and pepper. Bake in a greased bread tin about forty minutes. Serve with egg sauce and garnish with parsley.

ESPECIALLY in the wards, there's a certain amount of grumbling when supper trays appear. Sick people have a little more than their quota of human nature and nurses and dietitians are used to bearing the brunt.

Patient number three has a fractured leg. He's as well as he ever was. A couple of chops and a man sized dinner is normal for him. Patient number five may be in quite another boat. His diet for weeks to come may be a meatless one. His disposition's edgy when he gets a whiff of grilled lamb chops.

One way to win a smile from him is to display a new treat for his supper—Cream of Wheat Salmon Loaf. Underneath a crispy top it's invitingly white, delicately mixed with the salmon's pink. Egg sauce gives it added color and appetite wakening, while a jaunty sprig of parsley tops the whole.

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currents. No unpleasant shocks have been observed even when autocondensation is administered on one of these couches. There appears to be no danger of conveying electric shocks to the patient or to the technician when such metal couches are used.

In our experience we have found that for the usual physical therapy applications, a couch height of twenty-six inches is the most nearly ideal. Obviously it would be more satisfactory if it were possible to regulate the



*The spring is so placed that its head may be easily raised. Wooden gliders on the legs make it possible to roll the couch anywhere in the room.*

height of these devices upon which the patient is placed. However, a distance of twenty-six inches from the floor is a convenient one. It permits patients who have difficulty in getting on the usual table to get on the couch readily. Individuals who are disabled by the infirmity of age or by injuries to the bones, joints or soft parts of the lower or upper extremities can usually arrange to lie down upon a couch of this height without difficulty. We are all aware of the distress frequently experienced by such patients in their efforts to climb on top of the usual plinth. For the technician, too, this height is not inconvenient. The slight bending required for the application of plates or pads is not disturbing.

The diminished height of the couch is of advantage in the administration of ultraviolet radiations from the mercury vapor and quartz lamps. There is a limit to the height to which these lamps may be raised. Frequently this limit does not permit of sufficient distance between the burner and the patient lying on the usual plinth. The additional inches gained by the lower couch give greater leeway in varying the ultraviolet radiation distances.

A width of thirty inches is a convenient one. It is sufficiently roomy for the average sized patient and is not too wide for the technician.

The use of coil springs makes the couch restful for the patient. It permits the mattress and therefore the plates or pads used to come into better relation to the skin, in the various curves and hollows of the body where such electrode application is made. It is far better that the patient be at ease while he is undergoing treatment. A soft couch tends to make him less tense. The coil springs are sturdy. After a few years' use they seem to be as good as when they were first used.

The couch is easily cleaned.

It is not suggested that the use of this couch is preferable to the ordinary wooden plinth in all instances. In the administration of massage, for example, it may be better to place the patient on a more unyielding surface. For the administration of the usual physical therapeutic procedures, however, it has many advantages over the plinth.



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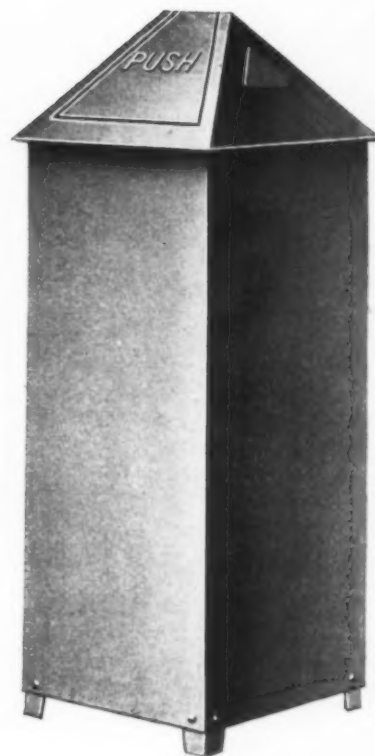
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## New Built-in Ventilator Said to Be Ideal for Hospitals

A built-in ventilator that is said to be ideal for hospitals is now being manufactured. The ventilator is constructed with patented R-shaped louvers and fits into a mortise cut in the window frame at the top or the bottom, or at both the top and the bottom. A sliding shutter inside permits the ventilator to be opened or closed easily. The built-in ventilator is three inches high, and is manufactured in lengths that will fit all sizes of windows in the hospital.

Changes were made in the shutter design of the new ventilator. The new shutter follows the modernistic trend of design with new angular shaped openings. The shutter is finished in a statuary bronze. Special finishes may be had to harmonize with any color scheme. The R-shaped louvers have been modified to increase their efficiency. The closed part of the "R" has been enlarged to check the air further and to give more space for the dropping of all particles that may be in the air. The two straight parts of the "R" have been shortened to permit an easier passage of air, which does not, the manufacturers say, in any way decrease the efficiency of the ventilator in effectually stopping all drafts.

Although designed to be built into the upper or lower, or both sash rails of windows, architects and builders are using built-in ventilators in walls, doors and other places with success.